

5948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>3 weeks</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Norma G.</i> Middle <i>Allender</i> Last <i>Allender</i>				4. DATE OF DEATH Month <i>May</i> Day <i>10</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 17 1921</i>	
9. AGE (In years lost birthday) <i>39</i> yrs.		10. IF UNDER 1 YEAR Months <i>39</i> Days <i>39</i> Hours <i>39</i> Min.		11. IF UNDER 24 HRS. Months <i>39</i> Days <i>39</i> Hours <i>39</i> Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Purchasing Agent</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Federal Government</i>			
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Wilson C Grady</i>				14. MOTHER'S MAIDEN NAME <i>Mary R. Hanlon</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
INFORMANT <i>David Allender</i>				Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i> DUE TO <i>Inferior vena cava thrombosis</i> DUE TO <i>Pelvic vein phlebitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>Unknown</i> <i>Unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>648.1 Hypertated mole.</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug</i> , 19 <i>52</i> to <i>May 10</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>May 10</i> , 19 <i>60</i> , and that death occurred at <i>1:05 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John Lawrence Avery</i> M.D.				ADDRESS (Street, city or town, state) <i>10110 Georgia Ave</i>			
PHYSICIAN'S NAME (Type) <i>John Lawrence Avery</i>				DATE SIGNED <i>May 10, 1960</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. & BURIAL</i>		22b. DATE THEREOF <i>5/13/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ROSE HILL CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>CUMBERLAND, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i> <i>Raymond E. Ziska</i>				ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 12 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Colleen S. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEATH OF DEATH

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5949

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont. Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>09 Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Baby Girl Anderson</i>		4. DATE OF DEATH <i>May 27 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>5/23/60</i>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>1</i> MONTHS <i>1</i> DAYS <i>1</i> HOURS <i>1</i> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Sherman Burnett</i>		14. MOTHER'S MAIDEN NAME <i>Janice Anderson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Quoric</i> <i>754.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Congenital Heart Disease</i> (c) <i>4 days</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 23, 1960</i> , to <i>May 27, 1960</i> , that I lost s/he the deceased alive on <i>May 27, 1960</i> , and that death occurred at <i>11:00 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Mabel H Grosvenor</i>		ADDRESS (Street, city or town, state) <i>2203 Wyoming Ave, NW Washington, D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Mabel Grosvenor</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-31-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak</i>	22d. LOCATION (City, town, or county) (State) <i>Gaithersburg, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler Funeral Home</i>		24. BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>1331 E. Montg. Rockville, Md.</i>		DATE <i>MAY 31 '60</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9-58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5950

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05849

Item 8 Film 6262 5/11/60 1wk

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 5 HR., 20 MIN.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosie Fay Arrington		4. DATE OF DEATH Month MAY Day 6 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PEARCE GLASS		14. MOTHER'S MAIDEN NAME Francy Bledsoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy, hemontogica DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on MAY 6 19 60 , and that death occurred at 6:10 PM from the causes and on the date stated above.			
22a. SIGNATURE A. D. Bonifant		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d. ADDRESS SANDY SPRING, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		23b. DATE THEREOF 5/7/60	
23c. NAME OF CEMETERY OR CREMATORY Berks Union Cemetery		23d. LOCATION (City, town, or county) (State) Scott County, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE MAY 9 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1950

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

10/15/1950

10/15/1950

ATTEST

BY

NOTARY

10/15/1950

10/15/1950

10/15/1950

10/15/1950

10/15/1950

10/15/1950

10/15/1950

None

None

10/15/1950

10/15/1950

10/15/1950

Notary Public for the State of Maryland
My Commission Expires 10/15/1950

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 222 Whitmoor Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Flora Augusterfer		4. DATE OF DEATH Month Day Year May 30 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1920
9. AGE (In years, lost birthday) 39 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gov't.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene B. Perry		14. MOTHER'S MAIDEN NAME Ruth A. Zea	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Ernest H. Augusterfer, Jr.		Address 9106 Ewing Dr. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread metastatic sarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sarcoma rt breast. DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 mos 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1953 , to May 30, 1960 , that I last saw the deceased alive on May 30, 1960 , and that death occurred at 11:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest E. Harmon M.D.		ADDRESS (Street, city or town, state) 9301 Colesville Rd DATE SIGNED 30 May 1960	
PHYSICIAN'S NAME (Type) Ernest E. Harmon		Silver Spring Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/2/60	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR DATE JUN 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

6852

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PLACE OF DEATH		MANNER OF DEATH	
HOME		NATURAL	
COUNTY OF ALABAMA		CITY OF BIRMINGHAM	
DECEASED		DECEASED	
DATE OF DEATH		DATE OF DEATH	
JANUARY 1, 1924		JANUARY 1, 1924	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
PLACE OF BURIAL		PLACE OF BURIAL	
HOME		HOME	
COUNTY OF ALABAMA		CITY OF BIRMINGHAM	
DECEASED		DECEASED	
DATE OF BURIAL		DATE OF BURIAL	
JANUARY 1, 1924		JANUARY 1, 1924	
TIME OF BURIAL		TIME OF BURIAL	
10:00 AM		10:00 AM	
PLACE OF INTERMENT		PLACE OF INTERMENT	
HOME		HOME	
COUNTY OF ALABAMA		CITY OF BIRMINGHAM	
DECEASED		DECEASED	
DATE OF INTERMENT		DATE OF INTERMENT	
JANUARY 1, 1924		JANUARY 1, 1924	
TIME OF INTERMENT		TIME OF INTERMENT	
10:00 AM		10:00 AM	
PLACE OF EXHUMATION		PLACE OF EXHUMATION	
HOME		HOME	
COUNTY OF ALABAMA		CITY OF BIRMINGHAM	
DECEASED		DECEASED	
DATE OF EXHUMATION		DATE OF EXHUMATION	
JANUARY 1, 1924		JANUARY 1, 1924	
TIME OF EXHUMATION		TIME OF EXHUMATION	
10:00 AM		10:00 AM	
PLACE OF REINTERMENT		PLACE OF REINTERMENT	
HOME		HOME	
COUNTY OF ALABAMA		CITY OF BIRMINGHAM	
DECEASED		DECEASED	
DATE OF REINTERMENT		DATE OF REINTERMENT	
JANUARY 1, 1924		JANUARY 1, 1924	
TIME OF REINTERMENT		TIME OF REINTERMENT	
10:00 AM		10:00 AM	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Olney</u>		c. LENGTH OF STAY IN 1b <u>2mo.-3 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>—</u> Last <u>Anton</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Samuel Anton</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Jessie Anton</u> Address <u>Rt 1, Darwood Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerosis, Genl.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>60</u> , to <u>May 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>60</u> , and that death occurred at <u>9:45 a.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.		ADDRESS (Street, city or town, state) <u>105 Russell Ave. Gathersburg, Md.</u> DATE SIGNED <u>5-23-60</u>	
PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville Meth. Laytonsville, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 27 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

X

<p>1. Name of deceased <i>John Doe</i></p>		<p>2. Sex <i>Male</i></p>		<p>3. Age <i>45</i></p>	
<p>4. Date of death <i>Jan 15 1950</i></p>		<p>5. Time of death <i>10:30 AM</i></p>		<p>6. Place of death <i>Home</i></p>	
<p>7. Cause of death <i>Heart Disease</i></p>		<p>8. Manner of death <i>Natural</i></p>		<p>9. Signature of physician <i>Dr. J. Smith</i></p>	
<p>10. Signature of registrar <i>John Doe</i></p>		<p>11. Signature of informant <i>John Doe</i></p>		<p>12. Signature of witness <i>John Doe</i></p>	

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05852

5931

1. PLACE OF DEATH a. COUNTY Montg, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 40Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Earl Middle Russell Last Bailey				4. DATE OF DEATH Month May Day 13 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 25-1879	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 8 Days 28 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter.				10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Zereppy Bailey				14. MOTHER'S MAIDEN NAME Cornelia Roberson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Ann C. Bailey. Gaithersburg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous, from DUE TO 1971-9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) primary epithelioma of face DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Several years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) 		(County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from March 26 1960 to May 13 1960 that (I) (we) lost the deceased alive on May 13 1960 , and that death occurred at 8 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Wm A. Linthicum				22b. DATE SIGNED 5/13/60		22c. PHYSICIAN'S NAME (Type) WM A. Linthicum	
22d. ADDRESS Rockville. Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-16-60		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town, or county) (State) Silver Spring. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Emmett C. Gaithersburg Md.				25a. REC'D BY REGISTRAR DATE MAY 16 '60		25b. REGISTRAR'S SIGNATURE Charles L. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05853

5952

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3700 Albemarle Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Imre Middle Peter Last Baka		4. DATE OF DEATH		Month May Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1883		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apartment House Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Housing		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? Hungary ✓	
13. FATHER'S NAME Imre Baka				14. MOTHER'S MAIDEN NAME Susanna Najj			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebellar hemorrhage 204-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myelogenous leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 25 , 19 60 , to May 5 , 19 60 , that I last saw the deceased alive on May 5 , 19 60 , and that death occurred at 7:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/6/60 ACTUAL SIGNATURE Jerry S. Trier M.D. The Clinical Center PHYSICIAN'S NAME (Type) Jerry S. Trier, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF May 9, 1960		22c. NAME OF CEMETERY OR CREMATORY Wash. Natl.		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 3072 M St N.W. Wash, D.C.		24a. REC'D BY REGISTRAR DATE MAY 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05854

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-1</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>184 Gaithersburg R-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Snuffer School Rd</u>				d. STREET ADDRESS <u>Snuffer School Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES EDWARD BAKER</u>				4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-58</u>	
9. AGE (in years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Ernest L. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Nanette Chick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ernest L. Baker</u>		Address <u>Stem</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart disease</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>life</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrocephalus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLOESCH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>5-31-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		22d. LOCATION (City, town, or country) (State) <u>md</u>	
23. FUNERAL DIRECTOR <u>Ernest C. Gartner, Gaithersburg</u>				24a. REC'D BY REGISTRAR <u>md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>JUN 3 '60</u>							

1225

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5954

CERTIFICATE OF DEATH

05855

Reg. Dist. No.

Item 9 Film 6263 5-19-60 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>445 Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>		1. d. STREET ADDRESS <u>5905 Ipswich Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First <u>Lee</u> Middle <u>Barbour</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12, 1878</u> 9. AGE (In years last birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Terrace Slayton</u>		14. MOTHER'S MARDEN NAME <u>Emma Gunther</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Bertha Breiden</u> Address <u>5905 Ipswich Rd, Bethesda Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Failure</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 days.</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> 1957, to <u>5/12</u> 1960, that I last saw the deceased alive on <u>5/12</u> 1960, and that death occurred at <u>7:15</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Y Jaggars Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave</u> DATE SIGNED <u>5/12/60</u>	
PHYSICIAN'S NAME (Type) <u>FRANK Y. JAGGERS JR.</u>		<u>Cherry Chase 15, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>5/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Banville, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 16 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

2022

44

1

Robert A. Thompson, Baltimore, Maryland, 5/1/00, 51 years old, died of heart disease, at his home, 1234 N. ...

Robert A. Thompson, Baltimore, Maryland, 5/1/00, 51 years old, died of heart disease, at his home, 1234 N. ...

5955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN lb <u>22 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>10415 GRANDIN ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALBERT F BARRY</u>				4. DATE OF DEATH Month Day Year <u>MAY 20 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 6, 1903</u>		9. AGE (In years last birthday) <u>56 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kaufmann Printing Co.</u>		11. BIRTHPLACE (State or foreign country) <u>St. John, New Brunswick, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>370-05-0820</u>		INFORMANT Address <u>Mrs. Clara A. Barry, 10415 Grandin Rd. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL EMPHYSEMA SECONDARY TO LEAKAGE OF GASTRO-ESOPHOGEAL ANASTOMOSIS</u> DUE TO (b) <u>PULMONARY INFARCTION AND EMBOLISM</u> DUE TO (c) <u>ADENOCARCINOMA FUNDUS STOMACH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>10 DAYS</u> <u>2 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 22</u> , 19 <u>59</u> , to <u>MAY 20</u> , 19 <u>60</u> that I last saw the deceased alive on <u>MAY 20</u> , 19 <u>60</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8907 GEORGIA AVENUE MAY 21, 1960</u>							
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D.				DATE SIGNED <u>MAY 21, 1960</u>			
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u>				<u>SILVER SPRING, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5956
CERTIFICATE OF DEATH

05857

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac		c. LENGTH OF STAY IN 1b Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Nursing Home		d. STREET ADDRESS 3900 Falls Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle G Last Bayly		4. DATE OF DEATH Month May Day 20 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/1865
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months 8 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME James P. Bayly		14. MOTHER'S MAIDEN NAME Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Brooke Brewer-Nephew-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH 1 week. 10 days.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER) non-contributory - Fracture of right femur -		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. Nov. 27 1958 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rockville, Montg. Md.	
21. I certify that (I) (this hospital) attended the deceased from July 28 1958 to May 20 1960 that (I) (we) last saw the deceased alive on March 18 1960 and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W. H. Fotherman, M.D.		22b. DATE SIGNED 5/20/60	
22c. PHYSICIAN'S NAME (Type) W. A. Linthicum, M.D.		22d. ADDRESS 110 S. West St., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/23/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE 		DATE MAY 24 '60	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5933
CERTIFICATE OF DEATH

05858

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 Mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				d. STREET ADDRESS <u>112 Lexington Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>V.</u> Last <u>BEAN</u>				4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-1882</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN A. BEAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY F. BLUNDON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Georgetown Rd.</u> Address <u>Bethesda, Md.</u> <u>Benj. E. Bean-Brother-8101 Old</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>102 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> to <u>17 May</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>5/15</u> , 19 <u>60</u> , and that death occurred at <u>9:50 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Aud</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/17/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. Aud</u>				22d. ADDRESS <u>9006 Colesville Rd. Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 20 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hayes</u>			



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112 Lexington Drive

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1
FOR STATE
HEALTH DEPT.

TO DELIVER BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18 Film 262 5-9-60 MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
5957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
65859									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bainbridge				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					d. STREET ADDRESS USNTC, Space #1, Bainbridge Vll.				
3. NAME OF DECEASED (Type or print) Bonnie Lynn BEAVER					4. DATE OF DEATH May 2 19 60				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-30-58		9. AGE (In years last birthday) 2 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Gene Whitmore BEAVER					14. MOTHER'S MAIDEN NAME Dorothy JONES				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT Hospital Records					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure									
872.0 DUE TO									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Acute Aspirin poisoning									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Reported to have taken a number of 5 gr. Aspirin tablets									
20c. TIME OF INJURY Month, Day, Year Hour e.m. xxx 4-30 1960			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Bainbridge Harford Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Frank J. BROSCART, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county) 5-2-60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment			22b. DATE THEREOF 5-3-60		22c. NAME OF CEMETERY OR CREMATORY Durham			22d. LOCATION (City, town, or country) (State) N.C.	
23. FUNERAL DIRECTOR W.W. Chambers Co., 1400 Chapin St., NW, WashDC					24a. REC'D BY REGISTRAR MAY 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume		

DEATH CERTIFICATE



7057

1-10-30

U. S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D. C.
No. 1-10-30
Name of deceased
Age
Sex
Color
Date of birth
Place of birth
Date of death
Place of death
Cause of death
Signature of physician
Signature of registrar
Signature of informant
Date of registration
Place of registration

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5958

CERTIFICATE OF DEATH

Reg. Dist. No. 05860

1. PLACE OF DEATH a. COUNTY MARYLAND Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 39 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac				d. STREET ADDRESS South Glen Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Kathleen Hollister Beer			4. DATE OF DEATH Month May Day 31 Year 19 60				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1953		9. AGE (In years last birthday) 7 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert A. Beer			14. MOTHER'S MAIDEN NAME Kathleen Costello				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 199.2 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) malignant Tumor - Unknown Primary DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 48 hours 4 mos							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 22, 1960 to May 31, 1960 , that I last saw the deceased alive on May 31, 1960 , and that death occurred at 3:55p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6-1-60 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Charles E. Mengel, M.D.		PHYSICIAN'S NAME (Type) Charles E. Mengel, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/60		22c. NAME OF CEMETERY OR CREMATORY St. Gabriel Cemetery		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 3 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1
CERTIFICATE OF DEATH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5902

05861

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Hellings</u> Last <u>Belt</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-30-80</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Howard A. Gilbert</u>				14. MOTHER'S MAIDEN NAME <u>Georgiana Hellings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Son - George H. Belt.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cervical carcinoma of Endometrium of Uterus.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1959</u> 19 <u>59</u> , to <u>May 1</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>April 30</u> 19 <u>60</u> , and that death occurred at <u>3:40 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James M. Whitlock M.D.</u>				22b. DATE SIGNED <u>May 1, 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK, M.D.</u>	
22d. ADDRESS <u>7717 Carroll Ave, Takoma Park 12 Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 3, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Th. H. Chambers</u>				25a. REC'D BY REGISTRAR <u>May 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>5801 Cleveland Ave</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5959 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY M ontgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg			c. LENGTH OF STAY IN lb 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hillside Apartments				d. STREET ADDRESS Hillside Apartments			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Arthur Blowers				4. DATE OF DEATH Month Day Year May 25 1960 19					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/13/1918		9. AGE (In years last birthday) 41 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drill press operator				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 085-12-2061		17. INFORMANT Address Kathleen Blowers (wife) Item 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage <div style="margin-top: 10px;"> 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shot gun wound thru heart & Great vessels DUE TO (c) </div> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH sudden </div> </div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by 2nd party at home					
20c. TIME OF INJURY Month, Day, Year 12:15 p.m. 5/25/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Clarksburg Montg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit				22b. DATE THEREOF 5/27/60		22c. NAME OF CEMETERY OR CREMATORY Greenwood		22d. LOCATION (City, town, or county) (State) Dunn, N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler-1331 E. Montgomery Ave. Rockville, Maryland				24a. REC'D BY REGISTRAR DATE MAY 27 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS DEPARTMENT OF HEALTH-BALTIMORE, 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. OCCUPATION [REDACTED]</p>		<p>8. EDUCATION [REDACTED]</p>		<p>9. MARITAL STATUS [REDACTED]</p>	
<p>10. CAUSE OF DEATH [REDACTED]</p>		<p>11. MANNER OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF EXAMINER [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>		<p>15. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>16. SIGNATURE OF WITNESS [REDACTED]</p>		<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>19. SIGNATURE OF WITNESS [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS [REDACTED]</p>		<p>21. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>22. SIGNATURE OF WITNESS [REDACTED]</p>		<p>23. SIGNATURE OF WITNESS [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>25. SIGNATURE OF WITNESS [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS [REDACTED]</p>		<p>27. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>28. SIGNATURE OF WITNESS [REDACTED]</p>		<p>29. SIGNATURE OF WITNESS [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>31. SIGNATURE OF WITNESS [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS [REDACTED]</p>		<p>33. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>34. SIGNATURE OF WITNESS [REDACTED]</p>		<p>35. SIGNATURE OF WITNESS [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>37. SIGNATURE OF WITNESS [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS [REDACTED]</p>		<p>39. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>40. SIGNATURE OF WITNESS [REDACTED]</p>		<p>41. SIGNATURE OF WITNESS [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>43. SIGNATURE OF WITNESS [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS [REDACTED]</p>		<p>45. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>46. SIGNATURE OF WITNESS [REDACTED]</p>		<p>47. SIGNATURE OF WITNESS [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>49. SIGNATURE OF WITNESS [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS [REDACTED]</p>		<p>51. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>52. SIGNATURE OF WITNESS [REDACTED]</p>		<p>53. SIGNATURE OF WITNESS [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>55. SIGNATURE OF WITNESS [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS [REDACTED]</p>		<p>57. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>58. SIGNATURE OF WITNESS [REDACTED]</p>		<p>59. SIGNATURE OF WITNESS [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>61. SIGNATURE OF WITNESS [REDACTED]</p>		<p>62. SIGNATURE OF WITNESS [REDACTED]</p>		<p>63. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>64. SIGNATURE OF WITNESS [REDACTED]</p>		<p>65. SIGNATURE OF WITNESS [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>67. SIGNATURE OF WITNESS [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS [REDACTED]</p>		<p>69. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>70. SIGNATURE OF WITNESS [REDACTED]</p>		<p>71. SIGNATURE OF WITNESS [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>73. SIGNATURE OF WITNESS [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS [REDACTED]</p>		<p>75. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>76. SIGNATURE OF WITNESS [REDACTED]</p>		<p>77. SIGNATURE OF WITNESS [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>79. SIGNATURE OF WITNESS [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS [REDACTED]</p>		<p>81. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>82. SIGNATURE OF WITNESS [REDACTED]</p>		<p>83. SIGNATURE OF WITNESS [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>85. SIGNATURE OF WITNESS [REDACTED]</p>		<p>86. SIGNATURE OF WITNESS [REDACTED]</p>		<p>87. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>88. SIGNATURE OF WITNESS [REDACTED]</p>		<p>89. SIGNATURE OF WITNESS [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>91. SIGNATURE OF WITNESS [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS [REDACTED]</p>		<p>93. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>94. SIGNATURE OF WITNESS [REDACTED]</p>		<p>95. SIGNATURE OF WITNESS [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>97. SIGNATURE OF WITNESS [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS [REDACTED]</p>		<p>99. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>100. SIGNATURE OF WITNESS [REDACTED]</p>		<p>101. SIGNATURE OF WITNESS [REDACTED]</p>		<p>102. SIGNATURE OF WITNESS [REDACTED]</p>	

5960

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>10 minutes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine</u> First Middle Last		4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-9 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
13. FATHER'S NAME <u>Andrew Galbraith</u>		14. MOTHER'S MAIDEN NAME <u>Ginnie McRae</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs. Robert McCormick-Daughter-2d</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent, post wall @ vent</u> DUE TO (b) <u>Thrombosis, right coronary artery</u> DUE TO (c) <u>Atherosclerosis, coronary arteries</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unknown</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>approx 24 hr</u>		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that I attended the deceased from <u>May 9</u> , 19 <u>60</u> , to <u>May 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>60</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.		23. ADDRESS (Street, city or town, state) <u>10511 Summit Ave Kensington, Md.</u> DATE SIGNED <u>5/15/60</u>	
24. ACTUAL SIGNATURE <u>George Sharpe</u> M.D.		24. PHYSICIAN'S NAME (Type) <u>George Sharpe</u>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		25b. DATE THEREOF <u>5/19/60</u>	
25c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		25d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
26. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		26. REC'D BY REGISTRAR <u>MAY 18 '60</u> 26. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

10580

CERTIFICATE OF DEATH

10580



W. R. R. R. R. R.

W. R. R. R. R.

W. R. R. R. R.

W. R. R. R. R.

Household

W. R. R. R. R.

W. R. R. R. R.

W. R. R. R. R.

W. R. R. R. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5961 CERTIFICATE OF DEATH

05864

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 8 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 2310 Colston Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby		First Boy		Last BRAY		4. DATE OF DEATH Month May Day 30 Year 1960	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-30-60	
9. AGE (In years lost birthday) 8 yrs.		IF UNDER 1 YEAR Months 8		IF UNDER 24 HRS. Days 11		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George August BRAY		14. MOTHER'S MAIDEN NAME Martha BARDENHAGEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 8 hours 8-11 am	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from May 30 6:10 pm to May 30 4:10 pm 19 60 that (I) (we) last saw the deceased alive on May 30 19 60 , and that death occurred at 4:10 pm from the causes and on the date stated above.							
22a. SIGNATURE D. Harris				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-31-60	
22c. PHYSICIAN'S NAME (Type) D. HARRIS, LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6-1-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR JUN 2 60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

MEDICAL CERTIFICATION

1

2

660 2 051261XV3

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05865

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>md</i>		b. COUNTY <i>montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN lb <i>10 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Rockville</i>		d. STREET ADDRESS <i>1 Beels mill Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Beels mill Rd</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary MacEachern Buchanan</i>		First Middle Last		4. DATE OF DEATH <i>May 10 1960</i>		Day Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-9-22</i>	
9. AGE (In years last birthday) <i>37</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Canada</i>	
13. FATHER'S NAME <i>Norman MacEachern</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Jan Buchanan - Husband - Item 2</i>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ethel alcohol & Barbituate poisoning</i> 888.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>0.29% ethel alcohol and 2.55 mg% Barbituate found in blood</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Found dead in bed</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. <i>- 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Mont.</i>		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		M.D.		DATE SIGNED <i>5-10-60</i>			
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/12/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		22d. LOCATION (City, town, or country) <i>Arlington, Virginia</i>		23. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 12 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>							

11102

2063



Robert A. Pomeroy, Bethesda, Maryland, April 1950
William National, Arlington, Virginia

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 5962
 CERTIFICATE OF DEATH

05866

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 44			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 9306 Parkhill Terrace							
3. NAME OF DECEASED (Type or print) First Margaret Middle A Last Bullion				4. DATE OF DEATH Month May Day 16 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/1876		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 0 Days 18 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Harmon Wolfe				14. MOTHER'S MAIDEN NAME Anna Lammers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Katherine Keller-Daughter-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETES MELLITUS + HYPERTENSION DUE TO (c) ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 3 HRS 6 YRS 10 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF LIVER							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda				20g. (County) Montgomery		20h. (State) Md	
21. I certify that (I) (this hospital) attended the deceased from May 16 1960 to May 16 1960 , that (I) (we) last saw the deceased alive on May 16 1960 , and that death occurred at 1959 M, from the causes and on the date stated above.							
22a. SIGNATURE Leo I Donovan				22b. DATE SIGNED 5/16/60			
22c. PHYSICIAN'S NAME (Type) Leo I Donovan				22d. ADDRESS 2218 Wisconsin Ave Bethesda 14 Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/60		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR MAY 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

074

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2

1

BP

5982

CERTIFICATE OF DEATH

County of ... State of ...
I, the undersigned, being a duly qualified medical officer of health for the County of ... do hereby certify that ...
Name of Deceased ...
Age ...
Sex ...
Race ...
Date of Death ...
Place of Death ...
Cause of Death ...
Signature of Medical Officer ...
Signature of Registrar ...

1

Lee I. Donovan

Report of ...
Signature of ...
Date ...

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5963 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05867

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Potomac		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 48 Bethesda		d. STREET ADDRESS 4900 Battery Lane	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 100 Yards off MacArthur Blvd. West of Falls Road.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry		First Middle Last L. BURLINGAME		4. DATE OF DEATH Month May Day 7 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1910 July 9, 1911	
9. AGE (In years last birthday) 48 4/9		IF UNDER 1 YEAR Months 9 Days 28		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Riverdale, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Burlingame				14. MOTHER'S MAIDEN NAME Sue C. Lamson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO. W. W. II		17. INFORMANT Estelle Burlingame-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 973.1 IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in auto with hose attached to exhaust					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED May 7, 1960			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/9/1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or country) (State) Suitland Maryland	
23. FUNERAL DIRECTOR Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAY 10 '60	
				24b. REGISTRAR'S SIGNATURE William S. Hume			

8

4

100 Yards off MacArthur Blvd.
East of Falls Road.

4300 Battery Lane

Bethesda

Maryland

Harry

BULLINGAME

NAV

Male

White

July 7, 1961

25-1/2 28

Attorney

Self-employed

Riverdale, Maryland

USA

Harry Burlingame

2nd C. Landon

Yes

W.W.H

Unknown

Battle Burlingame-2nd Landon

Carbon Monoxide Poisoning

Found dead in auto with hose attached to exhaust

FRANK J. BROSGART

Operation 5/9/1960

Cedar Hill

Bethesda

Maryland

Robert A. Bingham, Bethesda, Maryland

MAY 10 1960

May 7, 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5964 CERTIFICATE OF DEATH

05868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg,			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown. Rural				c. LENGTH OF STAY IN 1b 27 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gideon Middle Louis Last Bussard				4. DATE OF DEATH Month May Day 4 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29-1880	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months 9 Days 5		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturant. (Owner)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Thaddues Tyson Bussard				14. MOTHER'S MAIDEN NAME Ann Presscilla Murphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Address Margarett M. Bussard. Germantown. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Chronic Cardiac-renal disease DUE TO (c) Chronic osteo-myelitis Rt Shoulder - 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic osteo-myelitis Rt Shoulder - 10 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1959 , 19____, to _____, 19____, that I last saw the deceased alive on May 4 , 19 59 , and that death occurred at 11:52 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED F. J. Broschant M.D. Gaithersburg Md 5-5-60							
ACTUAL SIGNATURE F. J. Broschant PHYSICIAN'S NAME (Type) F. J. Broschant							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-7-60		22c. NAME OF CEMETERY OR CREMATORY St. Marys	
22d. LOCATION (City, town, or county) (State) Rockville. Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.				24a. REC'D BY REGISTRAR DATE MAY 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

4. 12. 1991

CERTIFICATE OF DEATH

Reg. Dist. No.

5880

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D. C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>10 Wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Deau Gardens Nursing Home</u>				d. STREET ADDRESS <u>1501--W--St., SE</u>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>M</u> Last <u>Butler</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep 8 1869</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Wm. E. Linden Jr.</u>				Address <u>4550--MacArthur Blvd NW Washington DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Chronic debilitation</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>February 19 60</u> to <u>May 3 1960</u> , that I last saw the deceased alive on <u>May 2 1960</u> , and that death occurred at <u>5:20p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u>				ADDRESS (Street, city or town, state) <u>10609 Concord Street May 3, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D.</u>				<u>Kensington Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Semmons Bros.</u>				ADDRESS <u>1661--Good Hope Rd SE Washington 20 DC</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2880

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of birth: Jan 1, 1900

5. Date of death: Jan 1, 1945

6. Place of death: Washington, D.C.

7. Cause of death: Heart Disease

8. Signature of physician: [Signature]

9. Signature of registrar: [Signature]

10. Date of registration: Jan 1, 1945

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05870

5965

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 207 Park Rd.	
3. NAME OF DECEASED (Type or print) First Holmes Middle Conard Last Caldwallader				4. DATE OF DEATH Month May Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/7/77	
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Virginia			
13. FATHER'S NAME Joseph Caldwellader				14. MOTHER'S MAIDEN NAME M arth a Carper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Daughter Mrs. Wilbert Shipe Same as Above			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 2. Severe Anemia DUE TO (c) 3. Pos. C.I. Malignancy				INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from May 7, 1960 to May 8, 1960 , that I last saw the deceased alive on May 7, 1960 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Linthicum				DATE SIGNED 5/8/60			
PHYSICIAN'S NAME (Type) William Linthicum				ADDRESS (Street, city or town, state) WILLIAM A. LINTHICUM, M.D. 110 South Washington St. ROCKVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Conder				ADDRESS Berryville		24a. REC'D BY REGISTRAR DATE MAY 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

90

CENTRAL A. E. OF DEATH

Marshall

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5966

CERTIFICATE OF DEATH

05871

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Earl Last Castle				4. DATE OF DEATH Month May Day 10 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1905 November 24, 1905	
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman - pipe fit.		11. BIRTHPLACE (State or foreign country) Gas & Electric Co., Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Castle				14. MOTHER'S MAIDEN NAME Mary I. Kissuel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-10-9813		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Bleeding DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Reticulum Cell Sarcoma DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28, 1960 , to May 10, 1960 that I last saw the deceased alive on May 10, 1960 , and that death occurred at 8:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 5-10-60 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Lawrence A. Gaydos		M.D. The Clinical Center					
PHYSICIAN'S NAME (Type) LAWRENCE A. GAYDOS, M.D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave		24a. REC'D BY REGISTRAR MAY 13 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

320

209 J

02/4/15

London Park Cemetery

BEITRÄGE

HOWARD H. HUBBARD

Wilkins Ave.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 5934 CERTIFICATE OF DEATH

05872

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 SILVER SPRING			
				d. STREET ADDRESS 12,800 Flack Street			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUSSELL Middle K. Last CAULK				4. DATE OF DEATH Month MAY Day 24 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/9/75	
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months 24 Days 24 Hours 1960		10. KIND OF BUSINESS OR INDUSTRY Minister Retired		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM B. CAULK		14. MOTHER'S MAIDEN NAME MARY E. KIRBY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Harry O. Caulk, 12,800 Flack St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accidents (Multiple) DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 1956 to 5-24 1960 , that (I) (we) last saw the deceased alive on 5-22 1960 , and that death occurred at 7 AM , from the causes and on the date stated above.							
22a. SIGNATURE Morris Perry				22b. DATE SIGNED 5-24-60			
22c. PHYSICIAN'S NAME (Type) Morris Perry				22d. ADDRESS 11602 Georgia Ave Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		23b. DATE THEREOF 5/27/60		23c. NAME OF CEMETERY OR CREMATORY SPRING GROVE CEMETERY		23d. LOCATION (City, town, or county) (State) MEDINA, OHIO	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR DATE MAY 27 '60			
ADDRESS SILVER SPRING, MD.				25b. REGISTRAR'S SIGNATURE Arthur L. Howard			

pp

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5967

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Pierce</u> 48X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1817 South 31st Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ashton Van Charles</u>				4. DATE OF DEATH Month Day Year <u>May 25 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 23, 1956</u>		9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ashton Charles</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastrointestinal hemorrhage</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute lymphatic leukemia</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aspergillosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>April 11</u> , 19 <u>60</u> , to <u>May 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>60</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles E. Mengel</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u>			DATE SIGNED <u>5/26/60</u>		
PHYSICIAN'S NAME (Type) <u>CHARLES E. MENGEL, M. D.</u>		National Institutes of Health <u>Bethesda 14, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>SOUTH SHORE KY.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Inc., 1400 Chapin St. N.W., Wash., D.C.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1961

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. PLACE OF DEATH</p>		<p>10. TIME OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. DATE OF DEATH</p>		<p>14. PLACE OF INTERMENT</p>	
<p>15. NAME OF FUNERAL HOME</p>		<p>16. NAME OF CEMETERY</p>	
<p>17. NAME OF MINISTER</p>		<p>18. NAME OF CHURCH</p>	
<p>19. NAME OF PRIEST</p>		<p>20. NAME OF RABBI</p>	
<p>21. NAME OF MINISTER</p>		<p>22. NAME OF CHURCH</p>	
<p>23. NAME OF PRIEST</p>		<p>24. NAME OF RABBI</p>	
<p>25. NAME OF MINISTER</p>		<p>26. NAME OF CHURCH</p>	
<p>27. NAME OF PRIEST</p>		<p>28. NAME OF RABBI</p>	
<p>29. NAME OF MINISTER</p>		<p>30. NAME OF CHURCH</p>	
<p>31. NAME OF PRIEST</p>		<p>32. NAME OF RABBI</p>	
<p>33. NAME OF MINISTER</p>		<p>34. NAME OF CHURCH</p>	
<p>35. NAME OF PRIEST</p>		<p>36. NAME OF RABBI</p>	
<p>37. NAME OF MINISTER</p>		<p>38. NAME OF CHURCH</p>	
<p>39. NAME OF PRIEST</p>		<p>40. NAME OF RABBI</p>	
<p>41. NAME OF MINISTER</p>		<p>42. NAME OF CHURCH</p>	
<p>43. NAME OF PRIEST</p>		<p>44. NAME OF RABBI</p>	
<p>45. NAME OF MINISTER</p>		<p>46. NAME OF CHURCH</p>	
<p>47. NAME OF PRIEST</p>		<p>48. NAME OF RABBI</p>	
<p>49. NAME OF MINISTER</p>		<p>50. NAME OF CHURCH</p>	
<p>51. NAME OF PRIEST</p>		<p>52. NAME OF RABBI</p>	
<p>53. NAME OF MINISTER</p>		<p>54. NAME OF CHURCH</p>	
<p>55. NAME OF PRIEST</p>		<p>56. NAME OF RABBI</p>	
<p>57. NAME OF MINISTER</p>		<p>58. NAME OF CHURCH</p>	
<p>59. NAME OF PRIEST</p>		<p>60. NAME OF RABBI</p>	
<p>61. NAME OF MINISTER</p>		<p>62. NAME OF CHURCH</p>	
<p>63. NAME OF PRIEST</p>		<p>64. NAME OF RABBI</p>	
<p>65. NAME OF MINISTER</p>		<p>66. NAME OF CHURCH</p>	
<p>67. NAME OF PRIEST</p>		<p>68. NAME OF RABBI</p>	
<p>69. NAME OF MINISTER</p>		<p>70. NAME OF CHURCH</p>	
<p>71. NAME OF PRIEST</p>		<p>72. NAME OF RABBI</p>	
<p>73. NAME OF MINISTER</p>		<p>74. NAME OF CHURCH</p>	
<p>75. NAME OF PRIEST</p>		<p>76. NAME OF RABBI</p>	
<p>77. NAME OF MINISTER</p>		<p>78. NAME OF CHURCH</p>	
<p>79. NAME OF PRIEST</p>		<p>80. NAME OF RABBI</p>	
<p>81. NAME OF MINISTER</p>		<p>82. NAME OF CHURCH</p>	
<p>83. NAME OF PRIEST</p>		<p>84. NAME OF RABBI</p>	
<p>85. NAME OF MINISTER</p>		<p>86. NAME OF CHURCH</p>	
<p>87. NAME OF PRIEST</p>		<p>88. NAME OF RABBI</p>	
<p>89. NAME OF MINISTER</p>		<p>90. NAME OF CHURCH</p>	
<p>91. NAME OF PRIEST</p>		<p>92. NAME OF RABBI</p>	
<p>93. NAME OF MINISTER</p>		<p>94. NAME OF CHURCH</p>	
<p>95. NAME OF PRIEST</p>		<p>96. NAME OF RABBI</p>	
<p>97. NAME OF MINISTER</p>		<p>98. NAME OF CHURCH</p>	
<p>99. NAME OF PRIEST</p>		<p>100. NAME OF RABBI</p>	

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 5968 CERTIFICATE OF DEATH

05874

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE (District of Columbia) b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16 d. STREET ADDRESS 6210 Newburn Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Myrick Last CHERRY				4. DATE OF DEATH Month May Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-12-10	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 57 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 57 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Artist				10b. KIND OF BUSINESS OR INDUSTRY Com. Art Studio		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John M. CHERRY				14. MOTHER'S MAIDEN NAME Grace WILSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon, Recurrent 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (we) (you) attended the deceased from May 12 1960 to May 19 1960 , that (I) (we) last saw the deceased alive on May 18 1960 , and that death occurred at 4:15 am , from the causes and on the date stated above.							
22a. SIGNATURE W. D. Hooper				22b. DATE SIGNED 5-19-60		22c. PHYSICIAN'S NAME (Type) W. D. HOOPER, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				ADDRESS Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR MAY 23 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Harris			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

5969

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05875

Items 13 & 14 Film 0263 5/11/60 iwk

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida		b. COUNTY Sanford					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 1021 West 3rd Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First William		Middle Owen		Last CHESSER		4. DATE OF DEATH Month May		Day 1		Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-3-08		9. AGE (In years lost birthday) 51 yrs.		IF UNDER 1 YEAR Months 51		IF UNDER 24 HRS. Days 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Georgia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 264-01-0718		17. INFORMANT Hospital Records		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 527.1 IMMEDIATE CAUSE (a) Pneumonia, rt. lower lobe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Delirium tremens DUE TO (c) Pulmonary emphysema, chronic										INTERVAL BETWEEN ONSET AND DEATH 6 days 2 days 8 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sanford		(County) Florida		(State)	
21. I certify that (I) was attended the deceased from April 28 19 60 to May 1 19 60 , that (I) was last saw the deceased alive on April 30 19 60 , and that death occurred at 2:35 PM , from the causes and on the date stated above.													
22a. SIGNATURE K M Moser				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 5-2-60					
22c. PHYSICIAN'S NAME (Type) K. M. MOSER, LT, MC, USNR				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				23b. DATE THEREOF 5-3-60		23c. NAME OF CEMETERY OR CREMATORY Sanford		23d. LOCATION (City, town, or county) Florida		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS WashDC				25a. REC'D BY REGISTRAR MAY 4 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Thoma			
W.W. Chambers Funeral Home, 1400 Chapin St., N.W.													

1. Name of Animal: _____
2. Sex: _____
3. Age: _____
4. Breed: _____
5. Date of Birth: _____
6. Date of Examination: _____
7. Name of Examiner: _____
8. Name of Owner: _____
9. Address: _____
10. City: _____
11. State: _____
12. Zip: _____
13. Telephone: _____
14. Occupation: _____
15. History of Illness: _____
16. Present Complaint: _____
17. Physical Examination: _____
18. Laboratory Tests: _____
19. Diagnosis: _____
20. Treatment: _____
21. Prognosis: _____
22. Remarks: _____

5970

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville--R.F.D.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Poolesville----R.F.D.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Emily Darby Brown Clark		4. DATE OF DEATH Month May Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24-1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Remus R. Darby		14. MOTHER'S MAIDEN NAME Antionette Chiswell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Mrs Walter Allnutt, Poolesville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 UREMIA DUE TO (b) HEPATO-RENAL SYNDROME DUE TO (c) GASTROINTESTINAL CARCINOMA OF LIVER			INTERVAL BETWEEN ONSET AND DEATH 6 weeks 2 years 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 1955 to MAY 7, 1960 , that I last saw the deceased alive on May 7, 1960 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Fawcett M.D.		ADDRESS (Street, city or town, state) Dawsonville	
PHYSICIAN'S NAME (Type) John Fawcett		DATE SIGNED P.O. Boyd	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 10-1960	22c. NAME OF CEMETERY OR CREMATORY Monocacy	22d. LOCATION (City, town, or county) (State) Beallsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR MAY 10 '60	
ADDRESS Barnesville, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1970

STATE OF MARYLAND

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

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Notary Public

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Notary Public

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5971

CERTIFICATE OF DEATH

05877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <u>Missouri</u> b. COUNTY <u>Camden</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN IB <u>72 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoutland</u> <u>62X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>Box 56</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Roy Clay, Jr.</u>				4. DATE OF DEATH Month Day Year <u>May 28 19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1937</u>		9. AGE (In years last birthday) <u>23</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Staff Sergeant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Roy Clay, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Minnie E. Ravenscroft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>488038-4006</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Metastases from</u> DUE TO (c) <u>Embryonal Cell Carcinoma, left Testis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 17</u> , 19 <u>60</u> , to <u>May 28</u> , 19 <u>60</u> , that I lost sowing the deceased olive on <u>May 28</u> , 19 <u>60</u> , and that death occurred at <u>2:10 p.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>5-28-60</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>Gordon C. Sharp</u> M.D.				PHYSICIAN'S NAME (Type) <u>GORDON C. SHARP, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stoutland, Missouri</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home, Inc.</u> <u>816 H St., NE, Wash, 2, DC</u>				24a. REC'D BY REGISTRAR <u>MAY 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5972

CERTIFICATE OF DEATH

05878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>58 days</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>McDowell Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Squire</u> <u>85X-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>No street address</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur</u> <u>(None)</u> <u>Coleman</u>			4. DATE OF DEATH Month Day Year <u>May</u> <u>25</u> <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 22, 1938</u>		9. AGE (In years last birthday) <u>21</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
13. FATHER'S NAME <u>Jessie A. Coleman</u>			14. MOTHER'S MAIDEN NAME <u>Bertha Coleman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>234-64-0303</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute suppurative pyelonephritis</u> <u>353.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myoclonus epilepsy</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>4 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 28</u> , 19 <u>60</u> , to <u>May 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>60</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>5/26/60</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>					
ACTUAL SIGNATURE <u>Paul H. Altrocchi, M.D.</u>			PHYSICIAN'S NAME (Type) <u>PAUL H. ALTROCCHI, M. D.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Transit</u>		22b. DATE THEREOF <u>5-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Coleman Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Thompson</u>			24. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>		
ADDRESS <u>Bethesda, Md.</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>		
25d. LOCATION (City, town, or county) (State) <u>McDowell County, W. Va.</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

DATE OF DEATH

DECEASED'S NAME
 SEX
 AGE
 OCCUPATION

PLACE OF BIRTH
 DATE OF BIRTH
 SEX
 AGE

CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH

DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

DECEASED'S NAME
 SEX
 AGE

PLACE OF BIRTH
 DATE OF BIRTH
 SEX
 AGE

CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH

DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

DECEASED'S NAME
 SEX
 AGE

PLACE OF BIRTH
 DATE OF BIRTH
 SEX
 AGE

CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH

DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

DECEASED'S NAME
 SEX
 AGE

PLACE OF BIRTH
 DATE OF BIRTH
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 AGE

CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH

DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

DECEASED'S NAME
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 AGE

PLACE OF BIRTH
 DATE OF BIRTH
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 AGE

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DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

DECEASED'S NAME
 SEX
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PLACE OF BIRTH
 DATE OF BIRTH
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 AGE

CAUSE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH

DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH

DECEASED'S NAME
 SEX
 AGE

PLACE OF BIRTH
 DATE OF BIRTH
 SEX
 AGE

1. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5881
CERTIFICATE OF DEATH

05879

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2902 Lindell Street				d. STREET ADDRESS 1 2902 Lindell Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM COLLIE				4. DATE OF DEATH Month Day Year MAY 19 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/14/88	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener				10b. KIND OF BUSINESS OR INDUSTRY Gardener		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert W. Collie				14. MOTHER'S MAIDEN NAME Barbara M. S. Glass			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 579-28-9231		17. INFORMANT Address Robert A. Linkins, 2902 Lindell St. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 Hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 19 MAY 1960 to 19 MAY 1960 that (I) (we) last saw the deceased alive on 19 MAY 1960 and that death occurred at 20 M. from the causes and on the date stated above.							
22a. SIGNATURE L.B. Snow				22b. DATE 5/20/60		22c. PHYSICIAN'S NAME (Type) L. B. SNOW	
22d. ADDRESS 7950 New Hampshire Ave., Langley Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/23/60		23c. NAME OF CEMETERY OR CREMATORY Middleburg Mem. Cemetery		23d. LOCATION (City, town, or county) (State) Middleburg, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR DATE MAY 24 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kneass	

37

3 Hrs

RECEIVED THEATRE

14 MAY 60 11 AM P1

14 MAY 60

7/2/60

2/20/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05880

5882

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9604 Evergreen Street</u>				d. STREET ADDRESS <u>9604 Evergreen St</u>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Marie</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 12, 1889</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10. UNDER 1 YEAR Months <u>11</u> Days <u>1</u> Hours <u>1</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bureau of Engraving</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Engraving</u>			
13. FATHER'S NAME <u>unknown Lang</u>				14. MOTHER'S MAIDEN NAME <u>Laura Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Pauline Collins</u> Address <u>9604 Evergreen St. Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1 Congestive Heart Failure</u> DUE TO (b) <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>April 14, 1958</u> to <u>May 3, 1960</u> , that I last saw the deceased alive on <u>May 2, 1960</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip C. Jones, M.D.</u>				ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u>			
PHYSICIAN'S NAME (Type) <u>Philip E. Jones, M.D.</u>				DATE SIGNED <u>Silver Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "New York City"]		DATE OF BIRTH [Faint text, possibly "Jan 15, 1910"]		PLACE OF DEATH [Faint text, possibly "New York City"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "Jan 20, 1955"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF INTERMENT [Faint text, possibly "St. John's Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE OF DEATH [Faint text, possibly "This is to certify that the above named person died on..."]		CERTIFICATE OF DEATH [Faint text, possibly "This is to certify that the above named person died on..."]		CERTIFICATE OF DEATH [Faint text, possibly "This is to certify that the above named person died on..."]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5973

CERTIFICATE OF DEATH

05881

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. STREET ADDRESS 4630 Edgefield Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Addie Middle M. Last COLVIN				4. DATE OF DEATH Month May Day 27 Year 19 60			
5. SEX Fe		6. COLOR OR RACE Wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1873	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY Virginia			
13. FATHER'S NAME Ezekiel Lynn				14. MOTHER'S MARRIED NAME Thelma Pridmore - Washington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO. no			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 10 years				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/1/59 , 19____, to 5/27/60 , 19____, that I last saw the deceased alive on 5/27/60 , 19____, and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5/27/60 DATE SIGNED							
ACTUAL SIGNATURE John E. Everett M.D.				PHYSICIAN'S NAME (Type) John E. Everett, M.D. 9400 Conn. Ave. Kensington, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5/30/60		Manassas		Manassas Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Clifford W. Brandell				24a. REC'D BY REGISTRAR Baker F. H.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	
ADDRESS Manassas, Va.				DATE MAY 31 '60			

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may be furnished by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5974 CERTIFICATE OF DEATH 05882

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 4 hrs. 15 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Estelle Middle N. Last Costello				4. DATE OF DEATH Month May Day 22 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 22, 1898		9. AGE (In years lost birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Unknown James E. Newton				14. MOTHER'S MAIDEN NAME Kate Newton Sarah Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret Shibler Address Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular hypertensive disease DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 1958 to May 22, 1960 that (I) (we) last saw the deceased alive on May 22, 1960 and that death occurred at 12:45 PM from the causes and on the date stated above.							
22a. SIGNATURE W. A. Linthicum				22b. DATE SIGNED 5/23/60		22c. PHYSICIAN'S NAME (Type) W. A. Linthicum, MD.	
				22d. ADDRESS 26 N. Summit Ave., Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-25-60		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lynon Wheeler Funeral Home - Rockville, Md.				25a. REC'D BY REGISTRAR DATE MAY 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

14
5883
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8,9 FilmG263 5-20-60 et
CERTIFICATE OF DEATH

05883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b since 1926	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 RICHMOND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	d. STREET ADDRESS 1 812 RICHMOND AVENUE
3. NAME OF DECEASED (Type or print) First ADA Middle V. Last COWGILL		4. DATE OF DEATH Month MAY Day 17 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/24/87 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Vet. Admr.	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Decompensation		12. CITIZEN OF WHAT COUNTRY? U.S.A. INTERVAL BETWEEN ONSET AND DEATH 3 days 15-20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 53 to 17 May 60 , that I last saw the deceased alive on 16 May 19 60 , and that death occurred at 6 4 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William D Aud		ADDRESS (Street, city or town, state) 906 Colman Rd Silver Spring Md	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		DATE SIGNED 5/17/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/19/60	
22c. NAME OF CEMETERY OR CREMATORY OAKWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) FALLS CHURCH, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR MAY 18 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	



1943

CERTIFICATE OF DEATH

STATE OF NEW YORK
COUNTY OF [illegible]
[illegible]
[illegible]

112 [illegible] AVENUE
[illegible]

AGE [illegible] YEARS
[illegible]

DECEASED [illegible]
[illegible]
[illegible]
[illegible]

DATE OF DEATH [illegible]
[illegible]

[illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]

[illegible]
[illegible]
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[illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05884

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Cal</u> b. COUNTY <u>Monterey</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Echo Hts</u>		c. LENGTH OF STAY IN 1b <u>8 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitola</u>		<u>43X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5107 Wisconsin Rd</u>				d. STREET ADDRESS <u>508 Sunset Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Kennedy Coyle</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9-7-1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. MONTHS <u>7</u>		11. DAYS <u>15</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>Joe. J. Kennedy</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Hancock</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Donald K Kennedy Coyle - Item 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>5/19/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>				22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>May 20 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							



Robert A. Humphrey
Residence, Maryland
Occupation, Exemptory
Cause of Death, ...
Date of Death, ...
Place of Death, ...
Signature, ...
Witness, ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
051
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5976
05885
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) Bethesda (Rural) c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park d. STREET ADDRESS 103 Holland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ireta Middle Glenna Last CROSSMAN		4. DATE OF DEATH Month May Day 25 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-24
9. AGE (In years lost birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wiley A. LYDICK		14. MOTHER'S MAIDEN NAME Lona E. KELLY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT (H) Philip J. Crossman, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombocytopenia DUE TO (c) Hodgkins Disease INTERVAL BETWEEN ONSET AND DEATH 6 mos 6 mos 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from May 12 10:15 60 to May 25 19 60 , that (I) (x) last saw the deceased alive on May 25 19 60 , and that death occurred at 10:15 P M, from the causes and on the date stated above.			
22a. SIGNATURE F. S. Caldwell		22b. DATE SIGNED 5-26-60	
22c. PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 5-29-60	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Lima Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE Robert S. Barranco		25a. REC'D BY REGISTRAR DATE JUN 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Howard		25c. REGISTRAR'S SIGNATURE	

OF ROBERTS. BARRANCO

9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 8

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Book: **WILLIAM FOX**

10. *Phylogenetic relationships*

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1. *Chlorophyll a* (Chl *a*)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5977
CERTIFICATE OF DEATH

05886

| | | | | | |
|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)
c. LENGTH OF STAY IN 1b
64 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
District of Columbia
b. COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
47X-3
d. STREET ADDRESS
4213 4th St., S.E. - Apt. #2
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First
Erazelle
Middle
Foshee
Last
CRUMPTON | | | 4. DATE OF DEATH
Month
May
Day
17
Year
1960 | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 8. DATE OF BIRTH
5-6-03 | | 9. AGE (In years last birthday)
57 yrs. | | 10. IF UNDER 1 YEAR
Months
5
Days
17
Hours
17
Min.
17 | |
| 11. BIRTHPLACE (State or foreign country)
Alabama | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Walter H. FOSHEE | | | 14. MOTHER'S MAIDEN NAME
Mary E. ODEN | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
267-34-1257 | | 17. INFORMANT
Hospital Records
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Breast
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
3 years | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Tampa | | 20g. (County)
Florida | | 20h. (State)
Florida | |
| 21. I certify that (I) physician attended the deceased from March 14 , 19 60 , to May 17 , 19 60 , that (I) xxx last saw the deceased alive on May 16 , 19 60 , and that death occurred at 7:15am , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
J. L. Beeby | | 22b. DATE SIGNED
5-17-60 | | 22c. PHYSICIAN'S NAME (Type)
J. L. BEEBY, LT, MC, USN | |
| 22d. ADDRESS
U.S. Naval Hospital, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial-Shipment | | 23b. DATE THEREOF
5-17-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Tampa | |
| 23d. LOCATION (City, town, or county)
Florida | | 23e. REGISTRAR'S SIGNATURE
Arthur S. Harris | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
R.A. PUMPHREY | | 25a. REC'D BY REGISTRAR
MAY 20 '60 | | | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Harris | | | | | |

CERTIFICATE OF DEATH

State of California

County of Los Angeles

City of Los Angeles

Age 45

U. S. Naval Hospital

Occupation

Residence

Marital Status

Date of Birth

Place of Birth

Sex

Cause of Death

Medical History

Signature of Physician

Signature of Registrar

No.

U. S. Naval Hospital, Los Angeles, Cal.

U. S. Naval Hospital, Los Angeles, Cal.

U. S. Naval Hospital, Los Angeles, Cal.

U. S. Naval Hospital, Los Angeles, Cal.

U. S. Naval Hospital, Los Angeles, Cal.

U. S. Naval Hospital, Los Angeles, Cal.

U. S. Naval Hospital, Los Angeles, Cal.

U. S. Naval Hospital, Los Angeles, Cal.

5924

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
55 Chevy Chase | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4911 Chevy Chase Blvd | | | | d. STREET ADDRESS
4911 Chevy Chase Blvd | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Clayton Middle T Last Cunningham | | | | 4. DATE OF DEATH
Month May Day 9 Year 19 60 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 5, 1880 | |
| 9. AGE (In years last birthday)
79 yrs. | | IF UNDER 1 YEAR
Months 7 Days 4 | | IF UNDER 24 HRS.
Hours 4 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Kansas | |
| 12. CITIZEN OF WHAT COUNTRY?
US | | | | | | | |
| 13. FATHER'S NAME
Charles Cunningham | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
Sp. Amer. Unknown | | 17. INFORMANT
Blanche E. Cunningham-wife-same 2d | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Pulmonary emphysema | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | | 22b. DATE THEREOF
5/8/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | |
| | | | | 22d. LOCATION (City, town, or county)
Suitland, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | 24a. REC'D BY REGISTRAR
MAY 10 '60 | | 24b. REGISTRAR'S SIGNATURE
Charles S. House | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5251

| | | | |
|--------------------------------------|--|--|--|
| NAME OF DECEASED
Mary Chase | | SEX
Female | |
| AGE
40 | | DATE OF BIRTH
1910 | |
| PLACE OF BIRTH
New York | | OCCUPATION
None | |
| MARITAL STATUS
Single | | CAUSE OF DEATH
Pulmonary tuberculosis | |
| PREVIOUS ILLNESS
None | | MEDICAL HISTORY
None | |
| SIGNATURE OF EXAMINER
[Signature] | | DATE
5/15/50 | |

5251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G263 5-23-60 et

5944

CERTIFICATE OF DEATH

05888

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montg, MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | c. LENGTH OF STAY IN 1b
5yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Private home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | |
| f. STREET ADDRESS
13118 Ardenes Ave | | g. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Fred Middle B Last Cushman | | 4. DATE OF DEATH
Month May Day 16 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept 2-1881 |
| 9. AGE (In years lost birthday)
78 yrs | | 10. IF UNDER 1 YEAR
Months 8 Days 14 Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Real Estate Broker.Selling Real Estate. | | 12. BIRTHPLACE (State or foreign country)
St.Johnsburg.Vt. | |
| 13. FATHER'S NAME
Edwin Cushman | | 14. CITIZEN OF WHAT COUNTRY?
U S A | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. MOTHER'S MAIDEN NAME
Emma Russell | |
| 17. SOCIAL SECURITY NO.
220-32-7328 | | 18. INFORMANT
Marian M. Cushman. As No 2 | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
420.0 DUE TO as manifest by
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
5 month | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 19 60 to May 16 19 60 that I last saw the deceased alive on May 16 19 60 , and that death occurred at 6 M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED
Watertown Conn. 5/17/60 | |
| ACTUAL SIGNATURE
Jack Schumacher | | PHYSICIAN'S NAME (Type)
Jack Schumacher M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-20-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
EverGreen Cemebeby | | 22d. LOCATION (City, town, or county) (State)
Watertown Conn. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Samuel G. Farnham | | 24a. REC'D BY REGISTRAR
DATE MAY 19 '60 | |
| ADDRESS
Faithsburg | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kane | |

5027

Abstract

06-03-0, Initial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5978
CERTIFICATE OF DEATH

05889

| | | | | | | | | | | | | | | | |
|--|--|---------------------------------|--|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)
c. LENGTH OF STAY IN 1b
26 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis
d. STREET ADDRESS
152 Defense Highway
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
Doris Rebecca DAUGHTRY | | | | 4. DATE OF DEATH
Month May Day 28 Year 19 60 | | | | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Cauc | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5 July 1911 | | 9. AGE (In years last birthday) yrs. 48 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Harry H. MILLER | | | | 14. MOTHER'S MAIDEN NAME
Kate GOLDEN | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
NA | | | | 17. INFORMANT
(Husband) Joe Everett DAUGHTRY | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
171X IMMEDIATE CAUSE (a) Anoxia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic Carcinoma to Lungs
DUE TO (c) Carcinoma of Cervix | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) XXXXXX attended the deceased from 2 May to 28 May 19 60 that (I) XX last saw the deceased alive on 28 May 19 60 , and that death occurred on 8:55 AM from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
E.S. BILLINGSLEY, LT MC USN | | | | | | 22b. DATE SIGNED
5-29-60 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
E.S. BILLINGSLEY, LT MC USN | | | | | | 22d. ADDRESS
U.S. Naval Hospital, Bethesda, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
June 1-1960 | | 23c. NAME OF CEMETERY OR CREMATORY
Annapolis National Cem. | | | | 23d. LOCATION (City, town, or county) (State)
Annapolis Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John M. Taylor, Son Annapolis Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 1 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hines | | | | | | | |

1983 1984

Horowitz

5884

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>District of Columbia</i> b. COUNTY <i>✓</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47X-3</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>571 University Blvd. East</i> | | | | d. STREET ADDRESS <i>800 Galloway Str., N.E.</i> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>JULIA REBECCA DAVENPORT</i> | | | | 4. DATE OF DEATH <i>May 26 1960</i> | | | |
| 5. SEX <i>female</i> | | 6. COLOR OR RACE <i>white</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Febr. 7, 1869</i> | |
| 9. AGE (In years last birthday) <i>91</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | | | |
| 13. FATHER'S NAME <i>Joe Ballard</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Betty Schooler</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT <i>Mrs. L. D. Fickling - 800 Galloway Str. N.E., D.C.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Sept. 10, 1959</i> , to <i>May 26, 1960</i> , that I last saw the deceased alive on <i>May 25, 1960</i> , and that death occurred at <i>4:45 A.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Eino Magi</i> | | | | ADDRESS (Street, city or town, state) <i>918 University Blvd. E. Silver Spring, Maryland</i> | | DATE SIGNED <i>5/26/60</i> | |
| PHYSICIAN'S NAME (Type) <i>EINO MAGI</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>5/28/60</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>K Roadside</i> | | 22d. LOCATION (City, town, or county) (State) <i>K Roadside Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas Funeral Home By: Arthur T. T...</i> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <i>MAY 27 '60</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5979

Item 7 Filing 204 6-3-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05891

| | | | | | | | |
|--|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>
c. LENGTH OF STAY IN lb <u>11 days</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saithersburg</u> 08
d. STREET ADDRESS <u>R7D#1 Emory Grove Rd.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>EMMELINE</u> Middle <u>DAVIS</u> Last <u>DAVIS</u> | | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>25</u> Year <u>1960</u> | | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 15, 1881</u> | 9. AGE (In years last birthday) <u>79</u> yrs. | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Redland Md.</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>Reuben Waters</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | INFORMANT Address
<u>Mrs. Sarah Braxton R7D#2 Box 59 Saithersburg Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>446X Severe Pulmonary Edema</u>
DUE TO (b) <u>Uremia</u>
DUE TO (c) <u>hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>5 days</u>
<u>5 yrs 6 15 AM</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Diabetic mellitus</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from <u>16 May, 1960</u> to <u>25 May, 1960</u> , that I last saw the deceased alive on <u>23 May, 1960</u> , and that death occurred at <u>6:54 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Arthur L. Howard</u> M.D. <u>11134 Georgia Ave Silver Spring Md</u> | | DATE SIGNED <u>May 25, 1960</u> | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5/28/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove.</u> | 22d. LOCATION (City, town, or county) (State)
<u>Emory Grove, Md.</u> | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u> | | | | |

80

5980

CERTIFICATE OF DEATH

05892

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Boyd's | | c. LENGTH OF STAY IN 1b
7 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Buck Lodge Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Ira Middle Lynnwood Last Davis | | 4. DATE OF DEATH
Month May Day 24 Year 19 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 14, 1881 |
| 9. AGE (In years last birthday)
78 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Own farm | |
| 11. BIRTHPLACE (State or foreign country)
Hyattstown, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Vernon Davis | | 14. MOTHER'S MAIDEN NAME
Clara Hayes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
216-03-6629 | |
| 17. INFORMANT
Mr. L. Lynnwood Davis, 1601 Glenallan Silver Spring, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Metastasis of Carcinoma
194X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of thyroid
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Cardiovascular disease.
ONSET AND DEATH
2 months
2 years | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 15 Decmbr 1959 to 24 May 1960 , that I last saw the deceased alive on 24 May 1960 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Gordon M. Smith | | ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 24 May 60 | |
| PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
May 27, 1960 | 22c. NAME OF CEMETERY OR CREMATORY
Hyattstown Meth. | 22d. LOCATION (City, town, or county) (State)
Hyattstown, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Olin L. Molesworth | | 24a. REC'D BY REGISTRAR
DATE MAY 26 '60 | |
| ADDRESS
Damascus, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

32

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05893

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN TB
1 week | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
LILLIAN | | 4. DATE OF DEATH
Month May Day 7 Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 16, 1921 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Housework | 11. BIRTHPLACE (State or foreign country)
Spilimbergo Italy |
| 13. FATHER'S NAME
Danillo | | 14. MOTHER'S MAIDEN NAME
Adele Colavina | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
ES | |
| 17. INFORMANT
Husband David De Berna rdo | | Address
Same as Above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage today
DUE TO (b) Congenital Aneurysm
DUE TO (c) of Cerebral Artery
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1, 1960 to May 7, 1960 that I last saw the deceased alive on May 6, 1960 , and that death occurred at 11:20 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
John J. Curry | | ADDRESS (Street, city or town, state)
10620 Georgetown Rd Silver Spring, Md. | |
| PHYSICIAN'S NAME (Type)
John J. Curry | | DATE SIGNED
5/8/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
5-11-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 22d. LOCATION (City, town, or county) (State)
Wheaton Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Co | | 24a. REC'D BY REGISTRAR
5801 Cleveland Ave Riverdale Md | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Knaus | | DATE
MAY 11 '60 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

32

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page*4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5885
CERTIFICATE OF DEATH

05894

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ALTHEA-WOODLAND NURSING HOME | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK | |
| 3. NAME OF DECEASED (Type or print)
First LUCY Middle CHASE Last DEVEREUX | | 4. DATE OF DEATH
Month MAY Day 9 Year 19 60 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/23/74 |
| 9. AGE (In years last birthday)
85 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 11. BIRTHPLACE (State or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Horace G. Chase | | 14. MOTHER'S MAIDEN NAME
Ellen M. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT
Mr. Edward C. Devereux, 7404 Glenside Dr. Takoma Park, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO 331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis
DUE TO
(c) Semility | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Fractured left hip | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 19 56 to May 60 , that (I) (we) last saw the deceased alive on May 8 19 60 , and that death occurred at 5 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Bernard A. Fitzgerald | | 22b. DATE SIGNED
5-9-60 | |
| 22c. PHYSICIAN'S NAME (Type)
BERNARD A. FITZGERALD | | 22d. ADDRESS
217 University Blvd E, S.S., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
TRANS. & BURIAL | | 23b. DATE THEREOF
5/12/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
OLD CEMETERY | | 23d. LOCATION (City, town, or county) (State)
HOPKINTON, NEW HAMPSHIRE | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Raymond E. Pumphrey, INC. | | 25a. REC'D BY REGISTRAR
DATE MAY 12 '60 | |
| ADDRESS
SILVER SPRING, MD. | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

1883

CERTIFICATE OF DEATH

1883

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CHIEF TALK

1883

TO DEPENDENT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5982 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05895

Reg. Dist. No.

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|---|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE <u>Ontario</u> b. COUNTY <u>Wentworth</u> ✓ | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>14 hr</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Essex</u> <u>90X-3</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>4700 Bradley Blvd. apt 201</u> | | | | d. STREET ADDRESS
<u>Essex</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Norma Jean</u> Middle <u>Diemer</u> Last <u>Diemer</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>3</u> Year <u>1960</u> | | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>12-4-1930</u> | | | |
| 9. AGE (In years last birthday)
<u>29</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-----</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Ontario - Canada</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>Canada</u> ✓ | | | | | | | | | |
| 13. FATHER'S NAME
<u>John T. Byrnes</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Helen Higgins</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | 17. INFORMANT
<u>Mrs. Chamberlin-sister-Mexico</u>
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Barbiturate poisoning (Trional)</u>
<u>970.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(a), stating the underlying cause last. DUE TO (c) <u> </u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Reported to have taken about 40-3grs Trional capsules</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>trional</u> | | | | | |
| 20c. TIME OF INJURY
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> | | Month, Day, Year
<u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | <u>May 3 1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | | | |
| <u>Bur-transit</u> | | <u>5/4/60</u> | | <u>Holy Sepulchre</u> | | <u>Hamilton, Ontario, Canada</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | | | ADDRESS
<u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 5 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hays</u> | |

303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|----------------------------------|--|-----------------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF MEDICAL OFFICER | | 17. SIGNATURE OF NURSE | | 18. SIGNATURE OF CHAPLAIN | |
| 19. SIGNATURE OF SOCIAL WORKER | | 20. SIGNATURE OF POLICE OFFICER | | 21. SIGNATURE OF JUDGE | |
| 22. SIGNATURE OF PROSECUTOR | | 23. SIGNATURE OF DEFENSE ATTORNEY | | 24. SIGNATURE OF JURY | |
| 25. SIGNATURE OF JUDGE | | 26. SIGNATURE OF JURY | | 27. SIGNATURE OF JURY | |
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5983

CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD. (D. of C.)</u> b. COUNTY <u>Pr. Geo.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rd. Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C. 16242</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SKIDFORD REST Home</u> | | d. STREET ADDRESS <u>6401 Walker Mill Rd. Wash.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Harry</u> First <u>Dockett</u> Middle Last | | 4. DATE OF DEATH
Month <u>5</u> Day <u>22</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 12, 1887</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR
Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u> | IF UNDER 24 HRS.
Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u> | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>John H. Dockett</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary M. Henderson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Record Prince Geo. County Hosp.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>
<u>433.1</u> DUE TO <u>Auricular Fibrillation</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Remote Cerebral Thrombosis</u>
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Remote Cerebral Thrombosis</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u>19</u>
p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-2</u> , 19 <u>59</u> , to <u>5-22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-21</u> , 19 <u>60</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Clive E. Jackson, M.D.</u> | | ADDRESS (Street, city or town, state) <u>202 Martin St., Rockville, Md. 52200</u> | |
| PHYSICIAN'S NAME (Type) <u>Clive E. Jackson</u> | | DATE SIGNED <u>5-22-60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5/25/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Gates of Heaven.,</u> | 22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> | | ADDRESS <u>Rockville, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>MAY 31 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>William E. Frank</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible handwriting throughout the main body of the certificate, likely bleed-through from the reverse side.]

[Faint, illegible text at the bottom of the page, possibly a signature line or footer.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5935 CERTIFICATE OF DEATH

05897

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> | | | |
| c. LENGTH OF STAY IN 1b <u>4 days</u> | | | | d. STREET ADDRESS <u>2630 Adams Mill Rd. NW</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Lydia</u> Middle <u>A.</u> Last <u>Dollison</u> | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>7</u> Year <u>1960</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6/18/72</u> | |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNMENT</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Edward Siegfried</u> | | | | 14. MOTHER'S MAIDEN NAME <u>KAZAH HANCOCK</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT Address <u>Mrs. Elizabeth Lentz-1015 Stirling Road Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart Failure</u>
DUE TO (b) <u>Generalized Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>5 yr</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERNAL BETWEEN ONSET AND DEATH</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 1958</u> to <u>May 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>May 5, 1960</u> , and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Arthur H. Lewis MD</u> | | | | 22b. DATE SIGNED <u>5/7/60</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>ARTHUR H. LEWIS</u> | | | | 22d. ADDRESS <u>1714 RI Ave NW Washington DC</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/10/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery-</u> | | 23d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S.H. Hines Co. 2901 14th St. N.W. Washington, D.C.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>MAY 9 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |

ATTORNEY AT LAW, 1000 15TH STREET, N.W., WASHINGTON, D.C. 20004

72

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5925
CERTIFICATE OF DEATH

05898

| | | | |
|---|-------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 9 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7412 Oak Lane</u> | | d. STREET ADDRESS <u>7412 Oak Lane</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Richard</u> First <u>Alan</u> Middle <u>Dorsey</u> Last | | 4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1960</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-25-51</u> |
| 9. AGE (In years last birthday) <u>9</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Bethesda, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Carl H. Dorsey</u> | | 14. MOTHER'S MAIDEN NAME <u>Nedra Nelson Dorsey</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>L</u> | |
| 17. INFORMANT <u>Carl H Dorsey - Father</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Rhabdomyosarcoma</u>
DUE TO <u>197-9</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Metastasis</u>
DUE TO (c) <u>Ascites-Anasarca</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1960</u> to <u>May 8, 1960</u> that (I) (we) last saw the deceased alive on <u>May 8, 1960</u> and that death occurred on <u>May 12, 1960</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thorval L. Hickman</u> M.D. | | 22b. DATE SIGNED <u>May 12, 1960</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Thorval L. Hickman</u> | | 22d. ADDRESS <u>2923 Nichols Ave SE Wash. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/14/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>MAY 13 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | |

100-100000

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH

100-100000

Robert A. Burrows, M.D.,
Surgeon General,
Department of Health,
Sacramento, California.

5903

CERTIFICATE OF DEATH

Reg. Dist. No. 05899

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | | | d. STREET ADDRESS <u>12613 Meadowood Drive</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mildred Florence Drury</u> | | | | 4. DATE OF DEATH Month Day Year <u>May 30 1960</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-13-86</u> | |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>Conn.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>EDWARD DUFF</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY ELLEN MAHER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | | |
| 17. INFORMANT <u>Hospital Records</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u>Diabetes</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. 8 yrs</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>5/28/1960</u> to <u>5/29/1960</u> , that I last saw the deceased alive on <u>5/29/1960</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Donald Nelson</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>10620 Georgia Ave, Silver Spring, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Donald Nelson</u> | | | | DATE SIGNED <u>10620 Georgia Ave, Silver Spring, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/2/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jaska</u> ADDRESS <u>SILVER SPRING, MD.</u> | | | | 24a. REC'D BY REGISTRAR <u>JUN 3 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05900

5936

(M)

| | | | | | | | |
|---|--|-------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>D.C. Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u> | | | | c. LENGTH OF STAY IN 1b <u>4 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Sophia</u> First Middle Last | | | | 4. DATE OF DEATH <u>May 22 1960</u> Month Day Year | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-11-86</u> | |
| | | | | 9. AGE (In years last birthday) <u>73</u> yrs. | | 10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>John Brogan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Burke</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Wm. Earl Durbin</u> Address <u>5716 Ogden Rd. Wash. D.C.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Rheumatoid Arthritis</u>
<u>722.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/15 1960</u> to <u>5/22 1960</u> , that (I) (we) last saw the deceased alive on <u>5/22 1960</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Robert F. Dyer M.D.</u> | | | | 22b. DATE SIGNED <u>5/22/60</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. DYER M.D.</u> | | | | 22d. ADDRESS <u>1835 Eye St. N.W. Wash. D.C.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u> | | 23b. DATE THEREOF <u>5/27/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>River Side, Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Gas City, Indiana</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>MAY 24 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

(M)

57

(1)

Robert A. Kennedy, Maryland, 1964
San Francisco, 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5984

CERTIFICATE OF DEATH

05901
Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Damascus | | c. LENGTH OF STAY IN 1b
years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
27213 Ridge Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Ernest Middle D. Last Duvall | | 4. DATE OF DEATH
Month May Day 26 Year 19 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 3, 1883 |
| 9. AGE (In years lost birthday)
76 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Own farm | |
| 11. BIRTHPLACE (State or foreign country)
Woodfield, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joseph M. Duvall | | 14. MOTHER'S MAIDEN NAME
Augusta Penn | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
215-24-7360 | |
| INFORMANT
Mrs Mamie A. Duvall, 27213 Ridge Rd. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
422-1 IMMEDIATE CAUSE (a) Enterioselebotic cardiovascular disease
DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost.
DUE TO (b)
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov-15 , 19 40 , to 5/26 , 19 60 , that I last saw the deceased alive on 5/26 , 19 60 , and that death occurred at 5P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
James P. Kerr | | ADDRESS (Street, city or town, state)
Damascus, Md. | |
| PHYSICIAN'S NAME (Type)
James P. Kerr | | DATE SIGNED
5/27/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 29, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Montgomery Meth. | | 22d. LOCATION (City, town, or county) (State)
Claggettville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Chas. L. Wolsworth | | 24a. REC'D BY REGISTRAR
JUN 1 '60 | |
| ADDRESS
Damascus, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur L. House | |



20

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5886
CERTIFICATE OF DEATH

05902

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b 20 years | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1522 Live Oak Drive | | d. STREET ADDRESS 1 1522 Live Oak Drive
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First EMILY H. Middle EADER Last | | 4. DATE OF DEATH
Month MAY Day 21 Year 19 60 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 23, 1897 |
| 9. AGE (In years lost birthday) 62 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | |
| 10b. KIND OF BUSINESS OR INDUSTRY Own home | | 11. BIRTHPLACE (State or foreign country) Austria | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles Russell | |
| 14. MOTHER'S MAIDEN NAME Julia Makre | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO. 579-03-7396 | | 17. INFORMANT Mr. Jesse M. Eader, 1522 Live Oak Dr. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma brain
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma parotid
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH
3 months
11 months | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | 21. I certify that (I) (this hospital) attended the deceased from July 19 59 to May 21 19 60 , that (I) (we) last saw the deceased alive on May 20 19 60 , and that death occurred at 10:35 A.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE Ernest A. Gould | | 22b. DATE SIGNED May 21 1960 | |
| 22c. PHYSICIAN'S NAME (Type) ERNEST A. GOULD | | 22d. ADDRESS 1302 18th St., N.W., Washington, D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 5/24/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY | | 23d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MD. (State) _____ | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Giska | | 25a. REC'D BY REGISTRAR MAY 25 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | | 25c. ADDRESS SILVER SPRING, MD. | |

29

[Faint, illegible handwriting]

05903

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park DOA | | c. LENGTH OF STAY IN 1b 15 d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. | | d. STREET ADDRESS 1433 NORTH WEST DR e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle Andrew Last Edelblut | | 4. DATE OF DEATH Month 5 Day 29 Year 1960 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-15-89 |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months 7 Days 1 Hours 0 Min. 0 | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exec. Printer | | 10b. KIND OF BUSINESS OR INDUSTRY . | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME MR. Andrew Edelblut | | 14. MOTHER'S MAIDEN NAME Wilhelmina Beckman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 10620 | |
| 17. INFORMANT Mrs. Grace Edelblut | | Address Sam | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420-1 DUE TO Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis 10 years
(c) Coronary Arteriosclerosis 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 day | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 15 1954 to May 29 1960 that (I) (we) last saw the deceased alive on May 29 1960 and that death occurred at 9:14 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John J. Curry | | 22b. DATE SIGNED 5/29/60 | |
| 22c. PHYSICIAN'S NAME (Type) John J. Curry | | 22d. ADDRESS 10620 Georgia Ave Suitland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE THEREOF 5/31/60 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 23d. LOCATION (City, town, or county) Suitland, Md. | | (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. | | 25a. REC'D BY REGISTRAR DATE MAY 31 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

51

CERTIFICATE OF DEATH

1900

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Name", "Age", "Sex", "Cause of Death" are faintly visible.]

[Faint, mostly illegible text at the bottom of the page, likely bleed-through from the reverse side. Some words like "Date", "Place", "Signature" are faintly visible.]

1 B M 090

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3937

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05904

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington</u> | | | | c. LENGTH OF STAY IN 1b
<u>29</u> <u>SILVER SPRING</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>KENSINGTON GARDENS NURSING HOME</u> | | | | d. STREET ADDRESS
<u>1538 RED OAK DRIVE</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Annie</u> Middle <u>Feldman</u> Last <u>Feldman</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>27</u> Year <u>1960</u> | | | |
| 5. SEX
<u>FEMALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>NOV. 22, 1887</u> | |
| 9. AGE (In years lost birthday)
<u>72</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>RUSSIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>ISRAEL LUSTGARTEN</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>SOPHIA</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>HOSPITAL RECORDS</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lobar Pneumonia, rt lung</u>
490X
DUE TO (b) <u>Generalized Arterio-sclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Cerebro-sclerosis</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>Undetermined</u>
<u>Undetermined</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month <u> </u> Day <u> </u> Year <u>19</u>
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1957</u> to <u>May 27, 1960</u> , that (I) (we) last saw the deceased alive on <u>May 27, 1960</u> , and that death occurred at <u>10:45 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>George L Ball</u> | | | | 22b. DATE SIGNED
<u>May 27, 1960</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>George L Ball</u> | |
| 22d. ADDRESS
<u>10622 Georgia Ave Silver Spring, Md</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>MAY 30, 1960</u> | | <u>WOODBINE BROTHERHOOD CEM</u> | | <u>WOODBINE</u> <u>N. J.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>B. Dargatzis & Sons</u> | | | | ADDRESS
<u>3541-14th. NW.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUN 1 '60</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hines</u> | | | |

29

5985

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|-------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown | | | c. LENGTH OF STAY IN 1b 9 months | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home | | | d. STREET ADDRESS 1 | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Harry Clay Fisk | | | 4. DATE OF DEATH Month Day Year May 31 1960 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 2-1876 | | 9. AGE (In years lost birthday) 83 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer, Wash. Star Newspaper | | | 10b. KIND OF BUSINESS OR INDUSTRY New York | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Harry C. Fisk | | | 14. MOTHER'S MAIDEN NAME Emma J. Nutt | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. 578-09-8998 | | INFORMANT Address Carroll Fisk, Dickerson, Md |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
610X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pylonephritis with uremia
DUE TO (c) Benign Prostatic Hypertrophy | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days
14 days
10 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis, Healed Pulmonary Tuberculosis | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from Dec 20, 1953 to 31 May 1960 , that I last saw the deceased alive on 31 May 1960 , and that death occurred at 10 P. M. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE John M. Smith | | | ADDRESS (Street, city or town, state) DATE SIGNED Barnesville, Md 1 June 60 | | |
| PHYSICIAN'S NAME (Type) Gordon M. Smith | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/3/60 | 22c. NAME OF CEMETERY OR CREMATORY St Marys | | 22d. LOCATION (City, town, or county) (State) Barnesville, Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE William B. Hillen | | | 24a. REC'D BY REGISTRAR JUN 6 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

CERTIFICATE OF DEATH

Deceased
Name
Age

Place of Birth
Date of Birth

Sex

Marital Status
Occupation
Cause of Death
Date of Death

Place of Death
Signature of Physician
Signature of Registrar

Official Seal

Remarks
Date of Burial
Place of Burial

Signature of Registrar
Date of Registration

Signature of Registrar
Date of Registration

Signature of Registrar
Date of Registration

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05906

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b
34
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d. STREET ADDRESS 12,820 CRISFIELD ROAD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARGARET Middle B. Last FISK | | 4. DATE OF DEATH
Month MAY Day 29 Year 1960 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT. 13, 1931 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (State or foreign country) Washington, D.C. |
| 13. FATHER'S NAME JOHN BUCKLEY | | 14. MOTHER'S MAIDEN NAME MARIE JOSHPHINE STRUDLEY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mr. Arthur E. Fisk, 12,820 Crisfield Rd. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Aspiration of vomitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Anesthesia | | Silver Spring, Interval BETWEEN ONSET AND DEATH 15 minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pregnancy - 2nd stage of labor | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Nausea - 2nd stage of labor - general anesthesia | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 1:45 5/29/60 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital | 20f. (City or town) (County) (State)
Bethesda, Montgomery Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/30/60 | |
| EXAMINER'S NAME (Type) FRANK J. BROSCHART | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 6/1/60 | 22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY | 22d. LOCATION (City, town, or county) (State)
MONTGOMERY COUNTY, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Ziska ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR JUN 2 '60 | 24b. REGISTRAR'S SIGNATURE Arthur E. Fisk |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

By

Beaufort

5987

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
29 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Resmor-5721 Grosvenor Lane | | | | e. STREET ADDRESS
5818 Sonoma Road | | | |
| 3. NAME OF DECEASED (Type or print) First - James Middle Aloysious Last Flanagan | | | | 4. DATE OF DEATH Month May Day 7 Year 1960 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 15, 1876 | |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Accountant | | | | 10b. KIND OF BUSINESS OR INDUSTRY
retired | | 11. BIRTHPLACE (State or foreign country)
Chicago | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | | | | |
| 13. FATHER'S NAME
Michael Flannigan
UNKNOWN (last name unknown) | | | | 14. MOTHER'S MAIDEN NAME
Mary Helena Dundon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 336-05-1104 | | | |
| 17. INFORMANT
Mrs. Maryhellen Black | | | | Address
5818 Sonoma Road, Beth., Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, prostate
DUE TO
(c) 4 years | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 week |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Aug 7, 1957 , to May 7, 1960 , that I last saw the deceased alive on May 4, 1960 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert G. Angle | | | | ADDRESS (Street, city or town, state) 5009 Del Ray Ave, Bethesda, Maryland | | | |
| DATE SIGNED 5/7/60 | | | | | | | |
| PHYSICIAN'S NAME (Type) ROBERT G. ANGLE | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | May 10/60 | | Royal Palm Cemetery | | St Petersburg Florida | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edmond J. Adams | | | | ADDRESS 748 - W. ... | | 24a. REC'D BY REGISTRAR | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Charles E. House | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

45

5988

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Damascus | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Damascus | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
25912 Woodfield Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Robert Middle Allan Last Floyd | | 4. DATE OF DEATH
Month May Day 13 , Year 19 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 24, 1921 |
| 9. AGE (In years last birthday)
38 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Accountant | | 10b. KIND OF BUSINESS OR INDUSTRY
Gov't. | 11. BIRTHPLACE (State or foreign country)
Thomasville, Mo. |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Bernie O. Floyd | |
| 14. MOTHER'S MAIDEN NAME
Ruth A. Thomas | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | |
| 16. SOCIAL SECURITY NO.
WW #2 326-26-4410 | | INFORMANT Address
Mrs Louise Floyd, Damascus, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion - left
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) DUE TO
INTERVAL BETWEEN ONSET AND DEATH
Immediate | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 1954 to May 12, 1960 , that I last saw the deceased alive on May 12, 1960 , and that death occurred at 12:45 a.m. the causes and an the date stated above.
ADDRESS (Street, city or town, state) 9830 Main Street, Damascus, Md. DATE SIGNED May 13, 1960 | | | |
| ACTUAL SIGNATURE M. McKendree Boyer M.D. | | PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 16, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
National Mem. Park | | 22d. LOCATION (City, town, or county) (State)
Falls Church, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Olin L. Mohr | | ADDRESS
Damascus, Md. | |
| 24a. REC'D BY REGISTRAR
MAY 17 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. House | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

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CENTRAL BANK OF DEATH

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05909

5989

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA | | | | c. LENGTH OF STAY IN 1b
5 hrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SUBURBAN HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle ELLEN Last FRANKE | | | | 4. DATE OF DEATH
Month MAY Day 15 Year 19 60 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/29/85 | |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleslady (retired) | | 11. BIRTHPLACE (State or foreign country)
Kansas | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleslady (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
Real Estate Co. | | 11. BIRTHPLACE (State or foreign country)
Kansas | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN HENRY LEE | | | | 14. MOTHER'S MAIDEN NAME
MARY ELLEN CAHILL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO.
496-24-9965 | | 17. INFORMANT
Silver Spring, Maryland
Mrs. Wm. J. Golden, 8810 Manchester Road | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction, Acute
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion due to
(c) Coronary atherosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hours
12 hrs
1-2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Pulmonary Edema, Acute | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 11, 1960 to May 15, 1960 , that (I) (we) last saw the deceased alive on May 15, 1960 , and that death occurred at 8:30 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
James A. Roberts | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/16/60 | |
| 22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS | | | | 22d. ADDRESS
8907 Ga. Ave., Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| TRANS. & BURIAL | | 5/17/60 | | CALVARY CEMETERY | | KANSAS CITY, MISSOURI | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
WARNER E. BUMPHREY, INC.
Raymond A. Jiska | | | | ADDRESS
SILVER SPRING, MD. | | 25a. REC'D BY REGISTRAR
DATE MAY 17 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

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CERTIFICATE OF DEATH

2322

John

NAME

AGE

SEX

DATE

TIME

PLACE

CAUSE

SIGNATURE

DATE

2322

John

CADWYLL

2322

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5990

CERTIFICATE OF DEATH

05910

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>44 Bethesda</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>4503 Traymore St.</u> | | d. STREET ADDRESS
<u>4503 Traymore St.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>James Thomas Gallahorn, Sr.</u> | | 4. DATE OF DEATH
Month Day Year
<u>May 18, 1960</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9/15/75</u> |
| 9. AGE (In years last birthday)
<u>84</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Supt. of Bldgs & Grounds Bureau Engraving Washington, D.C.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>James Thomas Gallahorn</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Elizabeth Gabriella Mullen</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>James T. Gallahorn, Jr. same as #2</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
<u>450.0</u> DUE TO
Congestive Heart Failure
Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>12mo</u>
<u>10yr</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Mar 15</u> , 19 <u>46</u> , to <u>May 18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>60</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Arthur H. Lewis</u> | | DATE SIGNED
<u>1714 R I Ave NW Wash DC</u> | |
| PHYSICIAN'S NAME (Type)
<u>ARTHUR H. LEWIS, MD WASH. DC</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 22b. DATE THEREOF
<u>5/18/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Suitland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>The S.H. Hines Co.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE MAY 19 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

44

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05911

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | |
|--|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN lb
4 1/2 hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
60 Potomac | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hos p. | | | d. STREET ADDRESS
10712 Burbank Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Joseph Hamilton Galliher 111 | | | 4. DATE OF DEATH
Month May Day 24 Year 1960 | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/19/1949 | | 9. AGE (In years last birthday)
11 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
student | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Fla. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
Jos. H. Galliher Jr. | | | 14. MOTHER'S MAIDEN NAME
Mildred Grove | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Father-Joseph H Galliher, Jr. same 2d | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
813X Bilateral cerebral contusion
DUE TO
(b) Left subdural hematoma
DUE TO
(c) Struck by automobile while riding bicycle | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fracture of left femur | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Struck by auto while riding bicycle | | | |
| 20c. TIME OF INJURY
Month, Day, Year
5/24 1960
Hour, min. 5:45 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
highway | 20f. (City or town)
Potomac | (County)
Montg. | (State)
Md. |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i>
EXAMINER'S NAME (Type) Frank J. Broschart | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/26/60 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
5/27/60 | 22c. NAME OF CEMETERY OR CREMATORY
Potomac Ch. Cem. | 22d. LOCATION (City, town, or county) (State)
Potomac, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Robert A. Pumphrey Bethesda, Maryland | | | 24a. REC'D BY REGISTRAR
DATE MAY 27 '60 | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 3 Film G263 5-31-60 et
5993
CERTIFICATE OF DEATH

05913

Reg. Dist. No.

| | | | |
|--|----------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Chevy Chase</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u> | | d. STREET ADDRESS <u>24918 Cumberland Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Henry Lastrapes Garland</u> | | 4. DATE OF DEATH <u>May 26 1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar 4, 1866</u> |
| 9. AGE (In years lost birthday) <u>94</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>Mar</u> Days <u>26</u> Hours <u>1960</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Law</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Lawyer</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>St Landry Parish, LA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>yes US</u> | |
| 13. FATHER'S NAME <u>Henry Lastrapes Garland</u> | | 14. MOTHER'S MAIDEN NAME <u>Julia Bullard</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs. Albritton-Daughter-same as 2d</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CAVERNOUS SINUS THROMBOSIS</u>
DUE TO <u>Basal Cell Carcinoma of Face</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Basal Cell Carcinoma of Face</u>
DUE TO (b) <u>Basal Cell Carcinoma of Face</u>
DUE TO (c) <u>Basal Cell Carcinoma of Face</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
<u>6 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO SCLEROSIS GENERAL</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>MAY 25</u> , 19 <u>60</u> to <u>MAY 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MAY 25</u> , 19 <u>60</u> , and that death occurred at <u>1:30 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert G. Angle</u> | | DATE SIGNED <u>5/26/60</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u> | | ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave. Bethesda, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 5/26/60</u> | | 22b. DATE THEREOF <u>5/26/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Poelousas Cath. Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Opelousas, Louisiana</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Maryland</u> | |
| 24a. REC'D BY REGISTRAR <u>MAY 27 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Robert L. Knack</u> | |

55

5994

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>1 1/2 months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor San.</u> | | e. STREET ADDRESS <u>16016 Roseland Lane</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Agnes</u> Middle <u>Isabelle</u> Last <u>Gray</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>1</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 13, 1879</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jack. Donaldson</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura Hagen</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Donald C. Gray</u> | | Address <u>6016 Roseland Lane, Rockville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cachexia</u>
DUE TO <u>Carcinomatosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Orbicular carcinoma</u>
DUE TO (c) <u>Orbicular carcinoma</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Approx 2 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Portal Hypertension due to carcinomatous infiltration of liver</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 1, 1960</u> to <u>May 1, 1960</u> , that I last saw the deceased alive on <u>May 1, 1960</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>4422 East-West Hwy., Bethesda 14, Md.</u> | |
| DATE SIGNED <u>5/1/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>George A. GRAY, JR.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5/4/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Maryland</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE MAY 4 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

IN SENATE,
January 1, 1901.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1899.

Published by the State of New York,
under the authority of the Senate,
in the year 1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5995

CERTIFICATE OF DEATH

Reg. Dist. No.

07064

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>North Carolina</u> b. COUNTY <u>✓</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>28 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Spindale</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
<u>The Clinical Center, Bethesda 14, Md.</u> | | | | d. STREET ADDRESS
<u>209 Power Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mary</u> Middle <u>Lucile</u> Last <u>Grose</u> | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>26</u> Year <u>1960</u> | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 27, 1902</u> | | 9. AGE (In years last birthday)
<u>58</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Textile Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Textile</u> | | 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Henry C. Carson, Sr.</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Hattie Wells</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>237-34-1567</u> | | 17. INFORMANT <u>The Medical Record</u> Address
<u>The Clinical Center, Bethesda 14, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>204-3 Cardio - Respiratory Failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myelogenous Leukemia</u>
DUE TO (c) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>48 hours</u>
<u>4 Months</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 28</u> , 19 <u>60</u> , to <u>May 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>60</u> , and that death occurred at <u>10:15 a</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>5-26-60</u>
ACTUAL SIGNATURE <u>Harold J. Fallon</u> M.D. <u>The Clinical Center</u>
<u>National Institutes of Health</u>
<u>Bethesda 14, Maryland</u>
PHYSICIAN'S NAME (Type) <u>HAROLD J. FALLON, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5-28-1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>BRITON</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Rutherford Co., N.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James L. Kellogg</u> | | | | ADDRESS
<u>Forest City, N.C.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 6 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Charles S. Hanes</u> | | | |

CLINICAL STATE OF DEATH

1. Name of Patient
2. Age
3. Sex
4. Date of Birth
5. Date of Admission
6. Date of Death
7. Time of Death
8. Cause of Death
9. Place of Death
10. Signature of Physician
11. Signature of Nurse
12. Signature of Hospital Administrator
13. Signature of Medical Examiner
14. Signature of Coroner
15. Signature of Jury
16. Signature of Witness
17. Signature of Doctor
18. Signature of Nurse
19. Signature of Hospital Administrator
20. Signature of Medical Examiner
21. Signature of Coroner
22. Signature of Jury
23. Signature of Witness
24. Signature of Doctor
25. Signature of Nurse
26. Signature of Hospital Administrator
27. Signature of Medical Examiner
28. Signature of Coroner
29. Signature of Jury
30. Signature of Witness
31. Signature of Doctor
32. Signature of Nurse
33. Signature of Hospital Administrator
34. Signature of Medical Examiner
35. Signature of Coroner
36. Signature of Jury
37. Signature of Witness
38. Signature of Doctor
39. Signature of Nurse
40. Signature of Hospital Administrator
41. Signature of Medical Examiner
42. Signature of Coroner
43. Signature of Jury
44. Signature of Witness
45. Signature of Doctor
46. Signature of Nurse
47. Signature of Hospital Administrator
48. Signature of Medical Examiner
49. Signature of Coroner
50. Signature of Jury
51. Signature of Witness
52. Signature of Doctor
53. Signature of Nurse
54. Signature of Hospital Administrator
55. Signature of Medical Examiner
56. Signature of Coroner
57. Signature of Jury
58. Signature of Witness
59. Signature of Doctor
60. Signature of Nurse
61. Signature of Hospital Administrator
62. Signature of Medical Examiner
63. Signature of Coroner
64. Signature of Jury
65. Signature of Witness
66. Signature of Doctor
67. Signature of Nurse
68. Signature of Hospital Administrator
69. Signature of Medical Examiner
70. Signature of Coroner
71. Signature of Jury
72. Signature of Witness
73. Signature of Doctor
74. Signature of Nurse
75. Signature of Hospital Administrator
76. Signature of Medical Examiner
77. Signature of Coroner
78. Signature of Jury
79. Signature of Witness
80. Signature of Doctor
81. Signature of Nurse
82. Signature of Hospital Administrator
83. Signature of Medical Examiner
84. Signature of Coroner
85. Signature of Jury
86. Signature of Witness
87. Signature of Doctor
88. Signature of Nurse
89. Signature of Hospital Administrator
90. Signature of Medical Examiner
91. Signature of Coroner
92. Signature of Jury
93. Signature of Witness
94. Signature of Doctor
95. Signature of Nurse
96. Signature of Hospital Administrator
97. Signature of Medical Examiner
98. Signature of Coroner
99. Signature of Jury
100. Signature of Witness

5996

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Saint Marys | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | c. LENGTH OF STAY IN 1b
30 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Great Mills 18X-2 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
No street address | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Anita Middle Beatrice Last Guy | | | | 4. DATE OF DEATH
Month May Day 4 Year 19 60 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
September 11, 1907 | |
| 9. AGE (In years last birthday) yrs. 52 | | 10. IF UNDER 1 YEAR
Months 5 Days 18 Hours 0 Min. 0 | | 11. IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. 0 | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Perry Abell | | | | 14. MOTHER'S MAIDEN NAME
Sarah Fulton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction & Irreversible Shock
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
Hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epidermoid Carcinoma of Tongue 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. 11:10P | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
The Clinical Center | |
| 20f. (City or town) (County) (State)
Bethesda 14, Maryland | | | | 21. I certify that I attended the deceased from April 4 , 19 60 , to May 4 , 19 60 , that I last saw the deceased alive on May 4 , 19 60 , and that death occurred at 11:10P , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Gordon C. Sharp M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED
The Clinical Center May 5, 1960
National Institutes of Health
Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) GORDON C. SHARP, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/7/60 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Joseph | | 22d. LOCATION (City, town, or county) (State)
Morganza, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. Clarke Mattingley Leonardtown, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE MAY 10 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

051

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5997 CERTIFICATE OF DEATH

05916

| | | | | | | | | | | | | | | | |
|---|--|--------------------------------------|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)
c. LENGTH OF STAY IN 1b
22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Virginia
b. COUNTY
Quantico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
83x-3
d. STREET ADDRESS
Qtrs. 2795-D, Marine Corps Schools
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First
Rebecca
Middle
Ann
Last
HALE | | | | 4. DATE OF DEATH
Month
May
Day
4
Year
1960 | | | | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2-29-60 | | 9. AGE (In years last birthday)
2 yrs. | | IF UNDER 1 YEAR
Months
2
Days
5 | | IF UNDER 24 HRS.
Hours
5
Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- - - - - | | | | 11. BIRTHPLACE (State or foreign country)
Virginia | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Walter Dillard HALE | | | | | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth ECKENRODE | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
None | | | | 17. INFORMANT
(F) Walter D. Hale, same as #2 above
Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Staphylococcal Pneumonia
754.5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tricuspid Atresia
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m.
p. m.
19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 12 , 19 60 to May 4 , 19 60 , that (I) (the last) saw the deceased alive on May 4 , 19 60 , and that death occurred at 2:20 PM , from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
F. W. GRELLO
22c. PHYSICIAN'S NAME (Type)
F. W. GRELLO, LT MC, USN | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-5-60 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
5/7/60 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cemetery | | | | 23d. LOCATION (City, town, or county) (State)
Westminister, Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J.E. Myers, Jr.
ADDRESS
Funeral Home, Westminster, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 9 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | | | | | |

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2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

CERTIFICATE OF DEATH

5926

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>N. Cherry Chase</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>3621 Glenmoor Drive</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Herbert</i> First <i>H.</i> Middle <i>H.</i> Last <i>Hall</i> | | 4. DATE OF DEATH <i>May 26</i> 19 <i>60</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Mar. 17, 1889</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Garage Manager - Hotel Continental Washington, D.C.</i> | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME
<i>Thomas Levi Hall</i> | | 14. MOTHER'S MAIDEN NAME
<i>Phoebe Ludwig Hall</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>577-05-3137</i> | |
| 17. INFORMANT <i>Kenneth D. Hall</i> | | Address <i>Bethesda, Md. 5917 Walton Rd.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>180x Congestive heart failure</i>
DUE TO <i>Coronary insufficiency</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary insufficiency</i>
DUE TO <i>Coronary arteriosclerosis</i>
(c) <i>Coronary arteriosclerosis</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>24</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary arteriosclerosis. Gastric ulcer</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<i>None</i> | |
| 20c. TIME OF INJURY
Hour a. m. <i>None</i> p. m. <i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Feb. 19, 1956</i> to <i>May 26, 1960</i> , that I last saw the deceased alive on <i>May 26, 1960</i> , and that death occurred at <i>2:45 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>John B. Umhan</i> M.D. | | ADDRESS (Street, city or town, state) <i>8805 Conn. Ave</i> DATE SIGNED <i>5/26/60</i> | |
| PHYSICIAN'S NAME (Type) <i>John B. Umhan</i> | | <i>Cherry Chase 15 MD</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 22b. DATE THEREOF
<i>5/28/60</i> | 22c. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek Cemetery</i> | 22d. LOCATION (City, town, or county) (State)
<i>Washington, D. C.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>The S. H. Hines Co.</i> | | 24a. REC'D BY REGISTRAR
<i>2901 14th St. N.W.</i> | |
| 24b. REGISTRAR'S SIGNATURE
<i>Charles L. Kline</i> | | DATE <i>MAY 31 '60</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

51

| | | | | | |
|--|--|---|--|--|--|
| NAME OF DECEASED
[Faint text, possibly "John Doe"] | | SEX
[Faint text, possibly "Male"] | | AGE
[Faint text, possibly "35"] | |
| PLACE OF BIRTH
[Faint text, possibly "New York"] | | DATE OF BIRTH
[Faint text, possibly "Jan 1, 1887"] | | PLACE OF DEATH
[Faint text, possibly "New York"] | |
| OCCUPATION
[Faint text, possibly "Teacher"] | | CAUSE OF DEATH
[Faint text, possibly "Heart Disease"] | | MANNER OF DEATH
[Faint text, possibly "Natural"] | |
| DATE OF DEATH
[Faint text, possibly "Dec 15, 1922"] | | TIME OF DEATH
[Faint text, possibly "10:30 AM"] | | PLACE OF INTERMENT
[Faint text, possibly "Catholic Cemetery"] | |
| SIGNATURE OF DECEASED
[Faint text, possibly "John Doe"] | | SIGNATURE OF WITNESS
[Faint text, possibly "John Doe"] | | SIGNATURE OF PHYSICIAN
[Faint text, possibly "John Doe"] | |
| SIGNATURE OF CLERK
[Faint text, possibly "John Doe"] | | SIGNATURE OF JUDGE
[Faint text, possibly "John Doe"] | | SIGNATURE OF SHERIFF
[Faint text, possibly "John Doe"] | |

This certificate is to be filled out by the physician or the coroner, and is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. It is to be used for the purpose of determining the cause of death, and for the purpose of determining the manner of death. It is to be used for the purpose of determining the place of death, and for the purpose of determining the place of interment. It is to be used for the purpose of determining the date of death, and for the purpose of determining the time of death. It is to be used for the purpose of determining the signature of the deceased, and for the purpose of determining the signature of the witness, the physician, the clerk, the judge, and the sheriff.

CERTIFICATE OF DEATH

Reg. Dist. No.

5938

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE NEW YORK b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
KENSINGTON | | | | c. LENGTH OF STAY IN 1b
4 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LAKE RONKONMA, LONG ISLAND 69X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
3314 OBERON ST. | | | | d. STREET ADDRESS
5 RICHARDS AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First EDWARD Middle T. F. Last HAMMER, SR. | | | | 4. DATE OF DEATH
Month MAY Day 8 Year 19 60 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/11/83 | 9. AGE (In years last birthday) yrs.
76 | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Civil Engineer (retired) Construction | | | | 11. BIRTHPLACE (State or foreign country)
New York City, N.Y. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Ernest Hammer | | | | 14. MOTHER'S MAIDEN NAME
Catherine Tyrell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
yes | | 17. INFORMANT
Mr. Ernest Hammer, 3314 Oberon St.
Kensington, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
420 DUE TO Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 day
(c) 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Feb 1, 1960 to May 8, 1960 , that I last saw the deceased alive on May 8, 1960 , and that death occurred at 11:27 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 10620 Georgia Ave DATE SIGNED 5/8/60
ACTUAL SIGNATURE John J. Curry M.D. Silver Spring, Md
PHYSICIAN'S NAME (Type) JOHN J. CURRY | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
TRANS. & BURIAL | | 22b. DATE THEREOF
5/11/60 | | 22c. NAME OF CEMETERY OR CREMATORY
ST. RAYMOND'S CEMETERY | | 22d. LOCATION (City, town, or county) (State)
BRONX, NEW YORK | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
WYNNER E. POMPHREY, INC.
Raymond E. Ziska | | | | ADDRESS
SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR
DATE MAY 11 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Christina S. Thomas | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED
JAMES EARL RAY | | 2. SEX
Male | | 3. AGE
35 | |
| 4. DATE OF DEATH
April 4, 1968 | | 5. TIME OF DEATH
2:01 PM | | 6. PLACE OF DEATH
Room 308, Airport Hotel, Memphis, Tennessee | |
| 7. CAUSE OF DEATH
Shot | | 8. MANNER OF DEATH
Suicide | | 9. PLACE OF BIRTH
Macon, Georgia | |
| 10. DATE OF BIRTH
April 24, 1932 | | 11. PLACE OF BIRTH
Macon, Georgia | | 12. OCCUPATION
Attorney | |
| 13. MARITAL STATUS
Single | | 14. EDUCATION
High School | | 15. RELIGION
Methodist | |
| 16. SOCIAL SECURITY NUMBER
[REDACTED] | | 17. PREVIOUS MARRIAGES
None | | 18. PREVIOUS DEATHS
None | |
| 19. SIGNATURE OF DECEASED
[Signature] | | 20. SIGNATURE OF WITNESS
[Signature] | | 21. SIGNATURE OF PHYSICIAN
[Signature] | |
| 22. SIGNATURE OF CORONER
[Signature] | | 23. SIGNATURE OF JUDGE
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| 25. SIGNATURE OF DECEASED'S NEXT OF KIN
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5887 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05919

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>montg</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN lb
<u>10 yrs</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>20 Silver Spring</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>1002 Navahoe Dr</u> | | | | d. STREET ADDRESS
<u>1002 Navahoe Dr</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Albert</u> Middle <u>A.</u> Last <u>Harrie</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>4</u> Year <u>1960</u> | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>7-12-1907</u> | |
| 9. AGE (In years last birthday)
<u>52</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> | | 11. IF UNDER 24 HRS.
Hours <u>0</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>ENGINEER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. GOVT</u> | | 11. BIRTHPLACE (State or foreign country)
<u>PA.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.C.</u> | |
| 13. FATHER'S NAME
<u>David Harrie</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>FANNIE CADES</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>198-07-7756</u> | | 17. INFORMANT
<u>Betty Harrie - Steen 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 4 1960</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 22b. DATE THEREOF
<u>5/6/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>NAT'L MEM. PARK</u> | |
| 22d. LOCATION (City, town, or country) (State)
<u>FALLS CHURCH VA.</u> | | | | | | | |
| 23. FUNERAL DIRECTOR
<u>Deleahy Funeral Home</u> | | | | ADDRESS
<u>4217-9 8th St NW</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 6 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | | | |

MEDICAL CERTIFICATION

010310

2823

10-20-68

W

1

01-8-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5998 CERTIFICATE OF DEATH

05920

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY P. Geo. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | c. LENGTH OF STAY IN 1b
66 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville 1641-2 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital | | | | d. STREET ADDRESS
6916 Standish Drive | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First George Middle Arthur Last HARRIS | | | | 4. DATE OF DEATH
Month May Day 26 Year 19 60 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-31-33 | |
| 9. AGE (In years last birthday)
26 yrs. | | 10. IF UNDER 1 YEAR
Months 26 Days 26 Hours 26 Min. | | 11. IF UNDER 24 HRS.
Months 26 Days 26 Hours 26 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Guard | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Govt. | | 11. BIRTHPLACE (State or foreign country)
Michigan | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Charles S. HARRIS | | | | 14. MOTHER'S MAIDEN NAME
Miranda McDougal | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes 1953-1956 | | | | 16. SOCIAL SECURITY NO.
1953-1956 | | 17. INFORMANT
Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforation gastric ulcer
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkins Disease
DUE TO
(c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (the hospital) attended the deceased from March 21, 1960 to May 26, 1960 , that (I) (we) last saw the deceased alive on May 26, 1960 and that death occurred at 2:45 pm from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
K M Moser | | | | 22b. DATE SIGNED
5-26-60 | | 22c. PHYSICIAN'S NAME (Type)
K. M. MOSER, LT, MC, USN | |
| 22d. ADDRESS
U.S. Naval Hospital, Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-31-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City, town, or county) (State)
Arlington Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Co., 5801 Cleveland Ave. | | | | 25a. REC'D BY REGISTRAR
DATE JUN 1 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

41

1

Hodgkins Disease

Perforation gastric ulcer

Hospital at Rochester
Rochester, N.Y.

W. S. Davis

Albany

Albany

Discharge Date 3-21-00

Ward

Room

Age

Sex

Occupation

Address

CERTIFICATE OF DEATH

1899

5999

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|-------------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
59 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Margaret Middle Elsie Last Harvey | | | | 4. DATE OF DEATH
Month May Day 19 Year 1960 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
January 17, 1894 | |
| 9. AGE (In years last birthday)
66 | | IF UNDER 1 YEAR
Months 66 | | IF UNDER 24 HRS.
Days 66 Hours 66 Min. 66 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
(Housewife) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
Charles Mackie | | | | 14. MOTHER'S MAIDEN NAME
Margaret M. Sullivan | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
Unascertainable | | | |
| 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Endometrium with Metastases to Lungs,
172X DUE TO Liver and Adrenals.
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
Years | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____
19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from March 21 , 19 60 , to May 19 , 19 60 , that I last saw the deceased alive on May 19 , 19 60 , and that death occurred at 2:00 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-19-60
ACTUAL SIGNATURE Saul Genuth M.D. National Institutes of Health
PHYSICIAN'S NAME (Type) SAUL GENUTH, M.D. Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
5/23/60 | | 22c. NAME OF CEMETERY OR CREMATORY
HOLY CROSS CEM. | | 22d. LOCATION (City, town, or county) PHILA (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. A. Huntman + Son | | | | 24. REG. BY REGISTRAR
5732 GEORGIA AVE. N.W.
DATE MAY 23 '60 | | | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17.

CERTIFICATE OF DEATH

1999

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

SIGNATURE OF DECEASED

SIGNATURE OF WITNESS

STATE OF CALIFORNIA

DATE

TIME

PLACE

STATE OF CALIFORNIA

DATE

TIME

PLACE

5888

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WASHINGTON 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Marilea Nursing Home | | | | d. STREET ADDRESS
1121 NEW HAMPSHIRE AVENUE, N.W., | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) Mary First A. Middle Hayes Last | | 4. DATE OF DEATH
Month MAY 30, Year 19 60 | | | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JAN. 27, 1881 | 9. AGE (In years last birthday)
79 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RET. SEAMSTRESS | | 10b. KIND OF BUSINESS OR INDUSTRY
SHADE SHOP | | 11. BIRTHPLACE (State or foreign country)
WASHINGTON, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
? DRUMMOND | | | | 14. MOTHER'S MAIDEN NAME
? MURPHY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
--- | | INFORMANT
THOMAS E. HAYES, 8705 FENWAY DR., BETHESDA, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
334X IMMEDIATE CAUSE (a) Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days
5 yrs | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/16/60 to 5/30/60 , that I last saw the deceased alive on 5/30/60 19 60 , and that death occurred at 9:20 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Donald Nelson M.D. | | | | ADDRESS (Street, city or town, state) 10620 Georgia Ave., Silver Spring, Md. DATE SIGNED 5/30/60 | | | |
| PHYSICIAN'S NAME (Type) Donald Nelson | | | | 10620 Georgia Ave., Silver Spring, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
6/1/60 | | 22c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 22d. LOCATION (City, town, or county) (State)
SUITLAND, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph Bauer's Sons ADDRESS 1756 Pa. Ave., NW | | | | 24a. REC'D BY REGISTRAR
DATE JUN 1 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Frank | |

STATE OF TEXAS
CERTIFICATE OF DEATH

Montgomery

Silver Spring

Medical Nursing Home

Female

1080 Georgia Ave., Silver Spring, MD

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 5905 CERTIFICATE OF DEATH

05923

| | | | | | | | |
|--|---------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>md</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u> | | | | c. LENGTH OF STAY IN 1b <u>1 week</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven</u> | | | | d. STREET ADDRESS <u>110002 Grayson Ave</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Heier Marie</u> | | First <u>Marie</u> Middle (NMI) <u>Heier</u> Last <u>Heier</u> | | 4. DATE OF DEATH <u>5</u> Month <u>14</u> Day <u>1960</u> Year | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb 27, 1892</u> | | 9. AGE (In years lost birthday) <u>68</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>STEPENACK</u>
<u>George</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ROSE</u>
<u>Gueschwent</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u> | | 17. INFORMANT <u>Lucile A. Kurok RN</u> Address <u>517 Albany Ave. Pk. Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Decompensation & pulmonary congestion</u>
<u>162.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unresected metastatic carcinoma</u> DUE TO <u>1-yr</u>
(c) <u>originating as bronchogenic carcinoma</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan, 1960</u> to <u>14 May, 1960</u> , that (I) (we) last saw the deceased alive on <u>14 May 1960</u> and that death occurred at <u>7:35 P</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Ernest E. Harmon</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon</u> | | | | 22d. ADDRESS <u>9301 Colesville Rd. Silver Spring Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u> | | 23b. DATE THEREOF <u>5/18/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEM. CEMETERY</u> | | 23d. LOCATION (City, town, or county) (State) <u>SUMERTON, PENNSYLVANIA</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Glick</u>
<u>WARNER E. PUMPHREY, INC.</u> | | | | ADDRESS <u>SILVER SPRING, MD.</u> | | 25a. REC'D BY REGISTRAR DATE <u>MAY 17 '60</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6000

CERTIFICATE OF DEATH

05924

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN lb
32 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | | | d. STREET ADDRESS
3108 University Boulevard West | | | |
| 3. NAME OF DECEASED (Type or print)
First Helen Middle Dorothy Last Henderson | | | | 4. DATE OF DEATH
Month May Day 17 Year 1960 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 15, 1900 | |
| 9. AGE (In years last birthday)
60 yrs. | | IF UNDER 1 YEAR
Months 2 Days 2 Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Statistical Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Government | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
John F. Gornnall | | | | 14. MOTHER'S MAIDEN NAME
Mary M. Beall | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
217-36-7397 | | | |
| INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO Bilateral Hydronephrosis and Pyelonephritis
secondary to partial Ureteral Obstruction by tumor 2 Weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Epidermoid Carcinoma, Uterine Cervix 9 Years
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 Minutes | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April 15 , 19 60 , to May 17 , 19 60 that I last saw the deceased alive on May 17 , 19 60 , and that death occurred at 11:35 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 5-17-60 | | | | | | | |
| ACTUAL SIGNATURE Jerry S. Trier | | | | M.D. The Clinical Center | | | |
| PHYSICIAN'S NAME (Type) JERRY S. TRIER, M.D. | | | | National Institutes of Health | | | |
| Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
5/20/1960 | | 22c. NAME OF CEMETERY OR CREMATORY
GLENWOOD CEMETERY | | 22d. LOCATION (City, town, or county) (State)
WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG COMPANY | | | | ADDRESS 300 N. ST., N.W. | | 24a. REC'D BY REGISTRAR
MAY 19 1960 | |
| DATE MAY 19 1960 | | | | 24b. REGISTRAR'S SIGNATURE Patricia L. Kraus | | | |

73

Montgomery Maryland

32 Days Kensington

The Clinical Center, Bethesda, Md., 3105 University Boulevard West

May 15 1960

March 12, 1960

U.S. Government Maryland U.S.A.

May 1, 1961

The Medical Center

3105 University Boulevard West, Bethesda, Md.

Cardiac arrest

Electrocardiogram and pathological examination of heart & lungs

Electrocardiogram, routine

May 17 11:35A

The Clinical Center
National Institutes of Health
Bethesda, Md., Maryland

WASHINGTON, D.C.

WILSON WOOD COMPANY
WASHINGTON, D.C.

WILSON WOOD COMPANY
WASHINGTON, D.C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05925

| | | | | | | | |
|---|---------------------------------|---|--------------------------------------|--|--------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Germantown | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
06 Germantown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Berryville Rd. | | | | d. STREET ADDRESS
Berryville Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Lucy Ann Henderson | | | | 4. DATE OF DEATH
Month May Day 23 Year 1960 | | | |
| 5. SEX
female | 6. COLOR OR RACE
col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-15-1881 | 9. AGE (In years last birthday)
78 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housework | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
D. J. Callahan Jr. Address Poolesville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
434.1 IMMEDIATE CAUSE (a) Acute Congestive Heart Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
36 hrs. | |
| 2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 2Dd. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED 5/24/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) (State) | |
| Burial | | 5/26/60 | | Lincoln Park., | | Rockville, Md. | |
| 23. FUNERAL DIRECTOR
Robert L. Swender | | | | ADDRESS
Rockville, Md. | | 24a. REC'D BY REGISTRAR
DATE MAY 31 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Huns | | | |



90

三

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5906 **CERTIFICATE OF DEATH**

05926

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK | | | | c. LENGTH OF STAY IN 1b
1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
WASHINGTON SAN. & HOSPITAL | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
36 SILVER SPRING | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle NORVAL Last HERBERT | | | | 4. DATE OF DEATH
Month MAY Day 24 Year 1960 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/20/06 | | 9. AGE (In years lost birthday)
53 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Printer - owner | | 10b. KIND OF BUSINESS OR INDUSTRY
ROCKVILLE PRESS | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WILLIAM U. HERBERT | | | | 14. MOTHER'S MAIDEN NAME
HELEN R. KANODE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
578-18-1313 | | 17. INFORMANT Address
Mrs. Margaret M. Herbert, 11802 Huggins Dr. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA, ACUTE
DUE TO 490-1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) CONGESTIVE HEART FAILURE, AC.
DUE TO 10 YRS.
(c) CORONARY ATHEROSCLEROSIS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PEPTIC ULCER | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1948 to 24 MAY 1960 , that (I) (we) last saw the deceased alive on 24 MAY 1960 , and that death occurred at 8 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
L. B. SNOW | | | | 22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/25/60 | |
| 22c. PHYSICIAN'S NAME (Type)
L. B. SNOW | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5/27/60 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION (City, town, or county) (State)
PRINCE GEO. COUNTY, MARYLAND | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Raymond A. Gusta | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Travis | |

36

Coronary Atherosclerosis
10 yrs
1 week
Trombolytic Therapy
Acute

Prize Vase

24 MAY 88

8/1

2/22/88

24 MAY 88

2/22/88

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|---|--|---|--|
| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 3c, Film G-265 6/20/60.cac.
6002
CERTIFICATE OF DEATH
05927
Reg. Dist. No. | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Poolesville R.F.D. | | | | | | c. LENGTH OF STAY IN 1b
5 mos. | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Matthews Nursing Home | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
10 Rockville | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | d. STREET ADDRESS
304 Anderson Ave | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First, JULIA Eliza Middle, HERSBERGER Last, HERSPERGER | | | | | | 4. DATE OF DEATH
Month MAY Day 7 Year 1960 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 22, 1880 | | 9. AGE (In years last birthday) yrs. 79 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Self employed | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | 13. FATHER'S NAME
Aaron Hersberger | | | | | | | |
| 14. MOTHER'S MAIDEN NAME
Hester Whipp | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No (If yes, give war or dates of service) | | | | | | | |
| 16. SOCIAL SECURITY NO.
INFORMANT | | | | Address
Mrs. John Backus Rockville, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 446X UREMIA
DUE TO Renal failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO Arteriosclerotic kidney disease
DUE TO Obesity
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Obesity | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
3 weeks
1 month
6 months | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
— | | | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Oct 5, 1959 to May 7, 1960 , that I last saw the deceased alive on May 6, 1960 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Dawsonville DATE SIGNED
ACTUAL SIGNATURE John G. Fawcett M.D. P. C. Beyals, M.D.
PHYSICIAN'S NAME (Type) John G. Fawcett | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
5/11/60 | | | | 22c. NAME OF CEMETERY OR CREMATORY
Monocacy | | | |
| 22d. LOCATION (City, town, or county)
Beallsville | | | | (State)
Md. | | | | 23. FUNERAL DIRECTOR'S SIGNATURE
Constance C. Hilton Barnesville, Md. | | | |
| 24a. REC'D BY REGISTRAR
DATE MAY 10 '60 | | | | 24b. REGISTRAR'S SIGNATURE
Charles L. Hume | | | | | | | |

5003

CERTIFICATE OF DEATH

John Robert

Married

Donations

Married

Age

Sex

Residence

Married

Residence

Married

Age

Married

Age

Married

Age

Married

Age

Married

Age

Married

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Age

Married

Age

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS-8. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|-------|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 6003 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 05928 | |
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <i>md</i> b. COUNTY <i>Montgomery</i> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | | | | | c. LENGTH OF STAY IN 1b Years <i>3 yrs</i> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4602 Chase Ave.</i> | | | | | | d. STREET ADDRESS <i>1 4602 Chase Ave.</i> | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>James Franklin Hewitt</i> | | | | | | 4. DATE OF DEATH <i>May 2 1960</i> | | | | | |
| 5. SEX <i>MALE</i> 6. COLOR OR RACE <i>W</i> | | | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |
| 8. DATE OF BIRTH <i>12-7-1906</i> | | | | | | 9. AGE (In years last birthday) <i>53</i> yrs. <input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Welding</i> | | | | | |
| 11. BIRTHPLACE (State or foreign country) <i>DC</i> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 13. FATHER'S NAME <i>Arron R. Hewitt</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>Mary El Burroughs</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>No</i> | | | | | | 16. SOCIAL SECURITY NO. <i>045-07-6728</i> | | | | | |
| 17. INFORMANT <i>Neice</i> Address <i>Kensington, Md</i> | | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>Intracranial Hemorrhage</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Spontaneous</i> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Contusions & lacerations</i> | | | | | | <i>Spontaneous</i> | | | | | |
| (c) <i>Fractured Skull</i> | | | | | | <i>Spontaneous</i> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture Compression, sixth cervical vertebrae</i> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Unknown/ Fell in basement of his home</i> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <i>? p.m. May ? 19 60</i> | | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work <input checked="" type="checkbox"/> | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i> | | | | | | 20f. (City or town) (County) (State) <i>Bethesda Mont Md.</i> | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DATE SIGNED <i>May 3 1960</i> | | | | | |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| Address (Street, city, town, or county) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | | 22b. DATE THEREOF <i>5/6/60</i> | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i> | | | | | | 22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i> | | | | | |
| 23. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> | | | | | | 24a. REC'D BY REGISTRAR <i>May 5 '60</i> | | | | | |
| ADDRESS <i>Bethesda, Maryland</i> | | | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | | | |

Robert A. Humphrey, Bethesda, Maryland
2/5/50
St. Mary's Cemetery, Rockville, Maryland
Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G262 5/13/60 1wk

05929

6004

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>3 days</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Lorenza</i> Middle <i>T</i> Last <i>Hill</i> | | 4. DATE OF DEATH
Month <i>May</i> Day <i>8</i> Year <i>1960</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7/3/96</i> |
| 9. AGE (In years last birthday) <i>63</i> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Animal Attendant Government</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>William Hill</i> | | 14. MOTHER'S MAIDEN NAME <i>Lavinia Butt</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>579-44-0320</i> | |
| 17. INFORMANT <i>Billie A. Howard - Bethesda</i> | | Address <i>R.F.D. #3</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Coronary thrombosis</i>
DUE TO
(c) <i>coronary arteriosclerosis</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>10 days</i>
<i>10 days</i>
<i>Indef.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral thrombosis</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Feb 1, 1960</i> , to <i>5/8/60</i> , 19 <i>60</i> that I lost saw the deceased alive on <i>5/8/60</i> , 19 <i>60</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Stephen N. Jones</i> M.D. | | ADDRESS (Street, city or town, state) <i>Rockville, Md.</i> DATE SIGNED <i>5/9/60</i> | |
| PHYSICIAN'S NAME (Type) <i>Stephen N. Jones</i> | | <i>809 Viers Mill Rd.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>5/11/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Potomac Church Cem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Potomac, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> | | ADDRESS <i>Bethesda, Maryland</i> | |
| 24a. REC'D BY REGISTRAR <i>MAY 10 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i> | |

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210-44-0120

Robert A. Humphrey, Maryland, 2/21/60
Thomas Church, Maryland, 2/21/60

6005

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Kempton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Clagettville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
RFD #1, Monrovia | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Iva Middle May Last Hilton | | 4. DATE OF DEATH
Month May Day 15 Year 19 60 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 13, 1897 |
| 9. AGE (In years last birthday)
62 yrs. | | 10. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Browningsville, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Maurice Watkins | | 14. MOTHER'S MAIDEN NAME
Martha XXXXXX King | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
INFORMANT
Mr. Ray Hilton, Monrovia, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Broncho-pneumonia
200.1 DUE TO Lympho-sarcoma
Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last.
(b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
2 days
11 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 59 , to May 15 , 19 60 , that I last saw the deceased alive on May 15, 1960 , and that death occurred at 4:30 PM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 9830 Main Street, Damascus, Maryland.
DATE SIGNED May 16, 1960 | | | |
| ACTUAL SIGNATURE M. McKendree Boyer, M.D.
PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
May 18, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Montgomery Meth. | | 22d. LOCATION (City, town, or county) (State)
Clagettville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Olin L. McIsaac | | 24a. REC'D BY REGISTRAR
DATE MAY 19 1960 | |
| ADDRESS
Damascus, Md. | | 24b. REGISTRAR'S SIGNATURE
Carroll | |

14

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INVESTIGATION OF THE
STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.
JAN 15 1900
TO THE COMMISSIONER OF THE LAND OFFICE
ALBANY, N. Y.
FROM THE ATTORNEY GENERAL
ALBANY, N. Y.
RE: THE LAND OFFICE
ALBANY, N. Y.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------|---|---|--|---|--|--|--|------------------------|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05931 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Mont Co.</u> <u>MARYLAND</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | | | c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Saint Hosp.</u> | | | | | | d. STREET ADDRESS <u>1300 Merriam Dr.</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mr. Morris Hollander</u> | | | | | | 4. DATE OF DEATH <u>5</u> <u>30</u> <u>1960</u> | | | | | |
| 5. SEX <u>m</u> | | 6. COLOR OR RACE <u>wh</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Mar 1890</u> | | 9. AGE (in years last birthday) <u>70</u> yrs. | | 10. IF UNDER 1 YEAR | |
| | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROGGER</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mrs. Reva -</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | | | | |
| 17. INFORMANT <u>Wife</u> | | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| <u>History of previous coronary disease</u> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DATE SIGNED <u>5-30-60</u> | | | | | |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| Address (Street, city, town, or county) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | 22b. DATE THEREOF <u>6/2/60</u> | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cem.</u> | | | 22d. LOCATION (City, town, or country) (State) <u>Hyattsville Md</u> | | |
| 23. FUNERAL DIRECTOR <u>Seabury Funeral Home</u> | | | | | | 24a. REC'D BY REGISTRAR <u>Jun 1 '60</u> | | | | | |
| ADDRESS <u>4217-9 - N.Y.</u> | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | | | | | |

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NEW YORK
JAN 10 1901

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6006

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
50 Bethesda | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4607 Harling Lane | | | | d. STREET ADDRESS
4607 Harling Lane | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) Emma B. Homer | | | | 4. DATE OF DEATH
Month May Day 15 Year 1960 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/22/79 | | 9. AGE (In years last birthday)
80 yrs. | IF UNDER 1 YEAR: Months 7 Days 23 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
US |
| 13. FATHER'S NAME
Ludwig L Holst | | | | 14. MOTHER'S MAIDEN NAME
Franciska Wanda | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Oscar Z Homer-Husband-same as 2d | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 min.

30 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. 11. p. m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from DEC. 1 , 19 54 , to May 15 , 19 60 , that I last saw the deceased alive on May 11 , 19 60 , and that death occurred at 9:50 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 6822X Norfolk Ave. Beth. Md DATE SIGNED 5/16/60 | | | | | | | |
| ACTUAL SIGNATURE John M. Wyman M.D. | | | | PHYSICIAN'S NAME (Type) John M. Wyman, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/18/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | ADDRESS
Bethesda, Maryland | | 24a. REC'D BY REGISTRAR
MAY 17 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Charles S. Kraus | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6007

05933

| | | | |
|---|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH CREEK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENBROOK FARM, DERWOOD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROOK GROVE FOUNDATION, INC.</u> | | 3. STREET ADDRESS <u>Derwood</u> | |
| 3. NAME OF DECEASED (Type or print) <u>FRANK W. HOOVER</u> | | 4. DATE OF DEATH <u>MAY 7 1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JUNE 20 '89</u> |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years, lost birthday) <u>70</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>San Manager of Post Services, WASH. D.C.</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>THOMAS ZEL HOOVER</u> | | 14. MOTHER'S MAIDEN NAME <u>ELICE SERENA HARRIS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>577-07-4639</u> | |
| 17. INFORMANT <u>W. W. I. HOOVER</u> | | Address <u>GLENBROOK FARM, DERWOOD, MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>350x Bronchopneumonia</u>
DUE TO (b) <u>Parkinsonism</u>
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>10 yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10/25/59</u> to <u>5/7/60</u> , that (I) (we) last saw the deceased alive on <u>5/1/60</u> , and that death occurred on <u>5/7/60</u> M, from the causes and on the date stated above. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/25/59</u> to <u>5/7/60</u> , that (I) (we) last saw the deceased alive on <u>5/1/60</u> , and that death occurred on <u>5/7/60</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>C. H. HIGON</u> | | 22b. DATE SIGNED <u>5/7/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>C. H. HIGON</u> | | 22d. ADDRESS <u>Sandy Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>5/11/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Maryland</u> | |
| 25a. REC'D BY REGISTRAR DATE <u>MAY 10 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | |

10000

CENTRAL AIR OF DEATH

10000

+

Robert A. Bumpus, Bethesda, Maryland
Buried in Arlington National Cemetery, Arlington, Virginia

6008

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda
c. LENGTH OF STAY IN 1b
75 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
District of Columbia
b. COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
47X-3
d. STREET ADDRESS
1345 Quincy Street, N.W.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Saxton Yates Howard | | | | 4. DATE OF DEATH
Month Day Year
May 23 1960 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 4, 1907 | |
| 9. AGE (In years last birthday)
53 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Technician | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Government | | 11. BIRTHPLACE (State or foreign country)
District of Columbia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William H. Howard | | | | 14. MOTHER'S MAIDEN NAME
Mary Ellen Yates | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
WW 11 | | 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
420.1 DUE TO Post splenectomy hypotension associated with blood loss
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. } DUE TO Coronary atherosclerosis
(c) Myeloid metaplasia in liver & spleen due to myelofibrosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes
3 1/4 hrs.
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 9 , 19 60 , to May 23 , 19 60 that I last saw the deceased alive on May 23 , 19 60 and that death occurred at 3:30 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/24/60
ACTUAL SIGNATURE Norman R. Gevirtz M.D. The Clinical Center
PHYSICIAN'S NAME (Type) Norman R. Gevirtz, M.D. National Institutes of Health
Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/27/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Oliver S. Howard | | | | 24a. REC'D BY REGISTRAR
DATE
MAY 25 '60 | | 24b. REGISTRAR'S SIGNATURE
Oliver S. Howard | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6009

CERTIFICATE OF DEATH

05936

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Brookville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville Rt 1</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sunshine - Glenwood Rd.</u> | | | | d. STREET ADDRESS <u>15 Sunshine Glenwood Rd</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Elias</u> First <u>Ridgely</u> Middle <u>Howes</u> Last | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1960</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6/23/1888</u> | |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | 11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Howes</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Helen Gaither</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>217-05-7317</u> | | 17. INFORMANT <u>Wife Susie R Howes</u> Address <u>Brookville Rt 1 W</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> | | | | | | | |
| (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 54 yr</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>10/25</u> , 19 <u>59</u> , to <u>5/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/19</u> , 19 <u>60</u> , and that death occurred at <u>4:00 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | | | ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>C. H. L. L. L.</u> | | | | DATE SIGNED <u>5/7/60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 10 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u> | | 22d. LOCATION (City, town, or county) <u>Sunshine</u> (State) <u>L#00000000 Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> | | | | ADDRESS <u>Laytonville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE MAY 11 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | | |

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

Items 20&21 Film 264 6-6-60
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05935

| | | | | | |
|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery | | Item 7 Film 6264 6-7-60 et | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | c. LENGTH OF STAY IN 1b
10 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
401 Anderson Ave | | | | d. STREET ADDRESS
401 Anderson Ave | |
| 3. NAME OF DECEASED
(Type or print)
Grace | | First Grace Middle B. Last Howes | | 4. DATE OF DEATH
May 27, 1960 19 | |
| 5. SEX Female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/5/1893 | 9. AGE (In years last birthday)
66 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher. | | 10b. KIND OF BUSINESS OR INDUSTRY
Mont. Co. Schools Md. | | 11. BIRTHPLACE (State or foreign country)
USA | |
| 13. FATHER'S NAME
Wm. J. Beall | | 14. MOTHER'S MAIDEN NAME
Mary E. Purdue | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
1 | | 16. SOCIAL SECURITY NO.
42-1936-7846 | | 17. INFORMANT
Police Record | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 816X Pulmonary embolism
DUE TO (b) Peripheral venous thrombosis
DUE TO (c) Fracture Right patella
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
unknown
22 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of auto involved in accident with another vehicle | | | |
| 20c. TIME OF INJURY
7:15 PM
Month, Day, Year
5/5/60 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
highway | 20f. (City or town)
Rockville | (County)
Montg. | (State)
Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
5/28/60 | |
| EXAMINER'S NAME (Type)
Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/31/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Parklawn | |
| 23. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home | | ADDRESS
1331 E. Montg. Ave | | 24a. REC'D BY REGISTRAR
Arthur L. Kruza | |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kruza | | 24c. DATE
MAY 31 '60 | |

RECEIVED
MAY 1960

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05937

Reg. Dist. No.

| | | | | | | | |
|--|--|---|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood, Bethesda
c. LENGTH OF STAY IN 1b Since 1931
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6408 Brookside Drive | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood, Bethesda
d. STREET ADDRESS 6408 Brookside Drive
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Dorothy Dulaney Hunter | | | 4. DATE OF DEATH
Month May Day 4 Year 19 60 | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 19, 1900 | | 9. AGE (In years last birthday) 59 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
Arthur W. Hodgkins | | | | |
| 14. MOTHER'S MAIDEN NAME
Alice W. Hutchens | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
[Yes, no, or unknown] No [If yes, give war or dates of service] | | | | |
| 16. SOCIAL SECURITY NO.
Unknown | | | 17. INFORMANT
S. A. Dulaney Hunter-Same Item #2 | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Coronary occlusion
 420.1 DUE TO Hypertension and generalized arteriosclerosis
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
 DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH
 sudden
 years </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart, | | | DATE SIGNED
May 4, 1960 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5/6/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | | |
| 22d. LOCATION (City, town, or county)
Arlington, Virginia | | 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | | |
| 24a. REC'D BY REGISTRAR
DATE MAY 5 '60 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6013

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

6013 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|-------------------------------|--|
| Name of Deceased | | John Doe | |
| Date of Death | | March 1931 | |
| Place of Death | | Home, Baltimore, Md. | |
| Cause of Death | | Heart Disease | |
| Manner of Death | | Natural | |
| Age | | 45 | |
| Sex | | Male | |
| Occupation | | Teacher | |
| Residence | | 1234 Main St., Baltimore, Md. | |
| Signature of Medical Examiner | | [Signature] | |
| Date of Examination | | March 1931 | |
| Signature of Coroner | | [Signature] | |
| Date of Issuance | | March 1931 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3889
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05938

| | | | |
|--|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | c. LENGTH OF STAY IN 1b
10 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
739 SLIGO AVENUE | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
24 SILVER SPRING | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle S. Last HUNTER | | 4. DATE OF DEATH
Month MAY Day 28 Year 19 60 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
1/9/83 |
| 9. AGE (In years last birthday)
77 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MACHINIST - High Standard Fire Arms Co. | | 10b. KIND OF BUSINESS OR INDUSTRY
MARYLAND | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN HUNTER | | 14. MOTHER'S MAIDEN NAME
MARGARET BARROWMAN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
040-05-3918 | |
| 17. INFORMANT
Mrs. Gordon Bonnette, 739 Sligo Ave. Silver Spring, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Failure (3 attacks in 3 months) sudden.
DUE TO (b) Chronic Myocarditis with freq. dysarrhythmia Feb 1956.
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/19/53 to 5/28/1960 , that (I) (we) last saw the deceased alive on 5/22/60 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Howard Morse | | 22b. DATE SIGNED
5/28/60 | |
| 22c. PHYSICIAN'S NAME (Type)
HOWARD T. MORSE | | 22d. ADDRESS
1630 Carroll Ave Takoma Park Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
ENTOMBMENT | | 23b. DATE THEREOF
5/31/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN MAUSOLEUM | | 23d. LOCATION (City, town, or county) (State)
PRINCE GEO. COUNTY, MARYLAND | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Raymond E. Pumphrey, INC. | | 25a. REC'D BY REGISTRAR
DATE JUN 2 '60 | |
| ADDRESS
SILVER SPRING, MD. | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

24

1

[Faint, illegible handwritten text, possibly a signature or address]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|------------------------------------|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>
c. LENGTH OF STAY IN 1b <u>D.O.D</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SAN & HOSPITAL</u> | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>
d. STREET ADDRESS <u>9132 PINEY BRANCH RD</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>JOHN</u> Middle <u>CHRISTOPHER</u> Last <u>JACOB</u> | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>5</u> Year <u>1960</u> | | | | 5. SEX <u>M.</u> | | | | 6. COLOR OR RACE <u>WHITE</u> | | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
<u>1-20-57</u> | | | | 9. AGE (In years last birthday) <u>3</u> yrs. | | | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>child</u> | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>none</u> | | | | | | | | 11. BIRTHPLACE (State or foreign country)
<u>WASHINGTON D.C.</u> | | | | | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME
<u>MR MOSS JACOBS</u> | | | | | | | | 14. MOTHER'S MAIDEN NAME
<u>JANET E. KUHNS</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>none</u> | | | | | | | | 16. SOCIAL SECURITY NO.
<u>none</u> | | | | | | | | 17. INFORMANT
Address <u>Mr. Moss Jacobs, Jr., 9132 Piney Branch Rd. Silver Spring</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u>
DUE TO <u>8/12x</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cerebral edema</u>
DUE TO <u>Auto injury</u>
(c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Laceration of liver</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.
<input type="checkbox"/> PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Pedestrian - struck by auto</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month <u>5</u> Day <u>5</u> Year <u>1960</u>
Hour <u>5:45</u> P.M. | | | | | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>street</u> | | | | | | | | 20f. (City or town) <u>Silver Spring Monty Md</u> (County) (State) | | | | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | | | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | Address (Street, city, town, or county) <u>5-6-60</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>CREMATION</u> | | | | | | | | 22b. DATE THEREOF
<u>5/9/60</u> | | | | | | | | 22c. NAME OF CEMETERY OR CREMATORY
<u>FT. LINCOLN CREMATORY</u> | | | | | | | | 22d. LOCATION (City, town, or country) (State)
<u>PRINCE GEO. COUNTY, MARYLAND</u> | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR
<u>WARNER E. PUMPHREY - INC.</u>
<u>Raymond A. Ziska</u> | | | | | | | | | | | | ADDRESS
<u>SILVER SPRING, MD.</u> | | | | | | | | | | | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 9 '60</u> | | | | | | | | 24b. REGISTRAR'S SIGNATURE
<u>Charles S. Evans</u> | | | | | | | |

5203

1

1

ORIGINAL - 52030

RECEIVED - 52030

COUNTY RECORDS

CLARK, J. B. (Jr.)

1950-1951

CLARK, J. B. (Jr.)

CLARK, J. B. (Jr.)

CLARK, J. B. (Jr.)

CLARK, J. B. (Jr.)

CLARK, J. B. (Jr.)

CLARK, J. B. (Jr.)

CLARK, J. B. (Jr.)

CLARK, J. B. (Jr.)

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CLARK, J. B. (Jr.)

CLARK, J. B. (Jr.)

CLARK, J. B. (Jr.)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05940

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN lb
132 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital | | | | d. STREET ADDRESS
612 West Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) | | First
Lois | | Middle
Elizabeth | | Last
JAMES | |
| 5. SEX
Female | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-2-15 | |
| 9. AGE (In years last birthday) yrs.
44 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (State or foreign country)
California | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Ross CARTER | | | | 14. MOTHER'S MAIDEN NAME
Lois PERSONS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
(H) Joseph James, same as #2 above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Colon to Metastasis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
18 Months | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour _____ a. m.
p. m. _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (do not) attended the deceased from _____ January 7, 1960, to _____ May 18, 1960, that (I) (we) last saw the deceased alive on _____ May 18, 1960, and that death occurred at _____ 3:40 am, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
J. L. Beeby | | | | 22b. DATE SIGNED
5-18-60 | | | |
| 22c. PHYSICIAN'S NAME (Type)
J. L. BEEBY, LT, MC, USN | | | | 22d. ADDRESS
U. S. Naval Hospital, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-20-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City, town, or county) (State)
Arlington Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W.E. Pumphrey | | | | 25a. REC'D BY REGISTRAR
MAY 20 1960 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

24

1. S. Naval Hospital
1. S. Naval Hospital

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1. S. Naval Hospital

6012

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>md.</i> b. COUNTY <i>Mont.</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>26 Silver Spring, Md.</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Thomas</i> Middle <i>E</i> Last <i>Jewett</i> | | | | 4. DATE OF DEATH
Month <i>May</i> Day <i>27</i> Year <i>1960</i> | | | |
| 5. SEX <i>MALE</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept. 18, 1882</i> | 9. AGE (In years lost birthday) <i>77</i> yrs. | IF UNDER 1 YEAR
Months <i>7</i> Days <i>10</i> Hours <i>15</i> Min. | IF UNDER 24 HRS.
Hours <i>15</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction Engineer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i> | | 11. BIRTHPLACE (State or foreign country) <i>PERBY, CONN.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S. A</i> | |
| 13. FATHER'S NAME <i>THOMAS E. Jewett</i> | | | | 14. MOTHER'S MAIDEN NAME <i>ADA M. GATES</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> | | 16. SOCIAL SECURITY NO. <i>080-10-0021</i> | | 17. INFORMANT Address <i>Wife (Mrs. Grace Jewett)</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>
433.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Heart Block</i>
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hemorrhage Lower Bowel</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>15 min</i>
<i>5 years</i> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May 27, 1960</i> to <i>May 27, 1960</i> that I last saw the deceased alive on <i>May 27, 1960</i> , and that death occurred at <i>10:00</i> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Bradley D. Hodgkins</i> | | ADDRESS (Street, city or town, state) DATE SIGNED <i>4413 Bradley Lane May 27, 1960</i> | | | | | |
| PHYSICIAN'S NAME (Type) <i>BRADLEY D. HODGKINS</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i> | | 22b. DATE THEREOF <i>5/31/60</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CREMATORY</i> | | 22d. LOCATION (City, town, or county) (State) <i>PRINCE GEO. COUNTY, MD.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i> ADDRESS <i>WARNER E. PUMPHREY INC SILVER SPRING, MD.</i> | | | | 24a. REC'D BY REGISTRAR DATE <i>JUN 2 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
6013
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
05942

| | | | |
|---|--------------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Washington, D.C. b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN 1b
29 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. NAVAL HOSPITAL | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington D.C.
47X-3
d. STREET ADDRESS
4016 13th Place N.E.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First August Middle William Last JOHNSON | | 4. DATE OF DEATH
Month May Day 21 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-7-1863 |
| 9. AGE (In years last birthday)
97 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
As a guard | | 10b. KIND OF BUSINESS OR INDUSTRY
Navy guard | |
| 11. BIRTHPLACE (State or foreign country)
Sweden | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO.
WW1 | |
| 17. INFORMANT
(W) Mrs Emma L. JOHNSON | | Address
4016 13th Pl. N.E., WDC | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
DUE TO 332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Thrombosis, nec. Middle Meningeal artery
DUE TO 3 weeks
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
3 hours
3 weeks | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) physician attended the deceased from April 21 19 60 to May 21 19 60 that (I) was last saw the deceased alive on May 21 19 60 and that death occurred at 9:30pm from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. M. Young | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
J. M. YOUNG LT MC USN | | 22d. ADDRESS
U.S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-24-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | | 23d. LOCATION (City, town, or county) (State)
Fort Lincoln Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lee Funeral Home | | 25a. REC'D BY REGISTRAR
DATE MAY 24 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. House | | | |

(M)

(1)

Montgomery

Washington, D.C.

Patients (Rural)

22 days

Washington D.C.

U.S. Naval Hospital

4010 13th Street N.W.

August

William

Johnson

new

SI

00

Male

Unmarried

5-7-1903

W

As a Guard

Heavy Guard

Unknown

U.S.A.

Unknown

Unknown

W

(W) 175 1/2 lbs. 5' 10" 1903 12.12.1903

*Presumably British
The patient was 175 1/2 lbs. 5' 10" 1903 12.12.1903*

Known

April 21

May 21

00

May 21

3:30 PM

Presumably

J. M. Young at MC 101

U.S. Naval Hospital, Bethesda, Md.

Serial

100-10

100-10

100-10

See General Report with a view to the patient's condition

May 2 - 1903

| Item 18 Film 2646360 | | | | | | | | | |
|--|--|---|--|---|--|--------------------------------------|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
| 6014 CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 05943 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia
b. COUNTY Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Herndon
d. STREET ADDRESS (No street address)
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First Ida Middle Retta Last Johnson | | | | | 4. DATE OF DEATH
Month May Day 23 Year 1960 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 16, 1899 | | 9. AGE (In years lost birthday) 61 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Virginia | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Joseph Gaskins | | | | | 14. MOTHER'S MAIDEN NAME Mary F. Jackson | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. Unascertainable | | | | |
| INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest due to blood loss
DUE TO (b) Hysterectomy, salpingo-oophorectomy, sigmoid colostomy, colon colostomy
DUE TO (c) colectomy
Carcinoma of the cervix
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | | | | | | |
| 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that I attended the deceased from May 11 , 19 60 , to May 23 , 19 60 , that I last saw the deceased alive on May 23 , 19 60 , and that death occurred at 5:25 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/24/60
ACTUAL SIGNATURE Robert M. Farrier, M.D.
PHYSICIAN'S NAME (Type) ROBERT M. FARRIER, M.D.
National Institutes of Health
Bethesda 14, Maryland | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 28 May 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Oak Grove Church, Cem. | | | 22d. LOCATION (City, town, or county) (State) Sterling, Virginia. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus
ADDRESS 1822 11th St. N.W. Wash. D.C. | | | | | 24a. REC'D BY REGISTRAR Arthur S. Kraus
DATE JUN 2 '60 | | 24b. REGISTRAR'S SIGNATURE | | |

State of Texas, County of ...

Know all men by these presents, that ...

for and in consideration of the sum of ...

to the said ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

the sum of ...

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6015

CERTIFICATE OF DEATH

05944

| | | | | | | | |
|--|----------------------------------|--|-----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY HOWARD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
OLNEY | | | | c. LENGTH OF STAY IN 1b
30 HRS. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ELLCOTT CITY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MONTGOMERY COUNTY GENERAL HOSP. | | | | d. STREET ADDRESS
Box 34 JONESTOWN | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
BRYAN WINIFRED JONES | | | | 4. DATE OF DEATH
Month Day Year
MAY 4 19 60 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/3/60 | | 9. AGE (In years last birthday) yrs.
30 | IF UNDER 1 YEAR
Months Days Hours Min.
30 25 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | | | | | | |
| 13. FATHER'S NAME
John Jones | | | | 14. MOTHER'S MAIDEN NAME
BARBARA ANN JONES | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
HOSPITAL RECORDS | | Address
OLNEY, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ATELECTASIS
7625 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) PREMATURITY (SIX MONTHS GESTATION)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/3/1960 to 5/4/60 , that (I) (we) last saw the deceased alive on 5/4/1960 , and that death occurred at 10:50A from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Charles S. Whitaker, | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type)
CHARLES S. WHITAKER, M. D. | |
| 22d. ADDRESS
CLARKSVILLE, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-8-60 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stephens | | 23d. LOCATION (City, town, or county) (State)
Elkridge, Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
F.C. Higinbotham, Ellicott City, Md | | | | 25a. REC'D BY REGISTRAR
DATE MAY 10 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Howard | |

CLARK AVE OF DOWNTOWN

2013

KNOWLEDGE TOWNS

AVIATION

RIGHTS

ELLIS CITY

30 APR

DEAD

JOE M. L. WILSON

ST. ANTHONY'S HOSPITAL

JAMES

W. L. L. L.

RYAN

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5909

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u> | | | | c. LENGTH OF STAY IN lb <u>Since May 24, 1960</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>Malanthum</u> Last <u>Keller</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-25-75</u> | |
| 9. AGE (In years lost birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR Months Days Hours | | IF UNDER 24 HRS. Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer (retired)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Produce</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Lou Keller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>unknown Keller</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | | |
| 17. INFORMANT <u>W.S. Hosp. Records</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
<u>420.0</u> IMMEDIATE CAUSE (a) <u>Myocardial insufficiency, acute,</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>4 days at least 10 years.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>November 28, 1951</u> , to <u>May 29, 1960</u> , that I last saw the deceased alive on <u>May 28, 1960</u> , and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Aaron H. Traum</u> | | | | ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring Md</u> DATE SIGNED <u>May 30, 1960</u> | | | |
| PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/1/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. PUMPHREY INC. Raymond A. Jaska</u> | | | | ADDRESS <u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR <u>JUN 2 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Trauma</u> | | | |

51

1

STATE OF OHIO
COUNTY OF CUYAHOGA
CITY OF CLEVELAND
IN SENATE
JANUARY 2, 1907
REPORT
OF THE
COMMISSIONERS OF THE
BUREAU OF
PUBLIC HEALTH
AND
VITAL STATISTICS
FOR THE
YEAR 1906
PUBLISHED BY THE
BUREAU OF
PUBLIC HEALTH
AND
VITAL STATISTICS
CLEVELAND, OHIO
1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6016 **CERTIFICATE OF DEATH**

05946

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|----------------------------------|--|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery Co</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>
c. LENGTH OF STAY IN 1b <u>55 days</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
d. STREET ADDRESS <u>1605 Woodman Ave</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Gertrude</u> First <u>L</u> Middle <u>Kenna</u> Last | | 4. DATE OF DEATH
Month <u>May</u> Day <u>24</u> Year <u>1960</u> | | 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>89</u> <u>Feb 5, 1888</u> | | 9. AGE (In years, last birthday) <u>71</u> <u>82</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done, or if retired, state so) <u>CLOTHING DESIGNER</u>
<u>housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>England</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>William Longfellow</u> | | | | 14. MOTHER'S MAIDEN NAME <u>EMILY GAYTHORPE</u> | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | | | 17. INFORMANT Address <u>Mrs. Edith M. King, 1605 Woodman Ave.</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the esophagus</u>
<u>150X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u>
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1959</u> to <u>May 24, 1960</u> that (I) (we) last saw the deceased alive on <u>May 22, 1960</u> and that death occurred at <u>3:40</u> M. from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>May 24, 1960</u> | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u> | | | | 22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u> | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 23b. DATE THEREOF <u>5/26/60</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u> | | | | 23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u> | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> | | | | ADDRESS <u>SILVER SPRING, MD.</u> | | | | 25a. REC'D BY REGISTRAR <u>MAY 27 '60</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u> | | | | | | | |

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CENTRAL OFFICE OF DEATH

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(1)

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(1)

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5910

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM</u> | | 1. d. STREET ADDRESS <u>905-N. Belgrade Rd</u> | |
| 3. NAME OF DECEASED (Type or print) <u>LAUREN JEAN Kessler</u> | | 4. DATE OF DEATH <u>May 21 1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 12, 1959</u> |
| 9. AGE (In years, last birthday) <u>1</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Elliott M. Kessler</u> | | 14. MOTHER'S MAIDEN NAME <u>Sandra Gold</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Elliott Kessler</u> Address <u>905 N. Belgrade Rd. S.S. Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>754.5</u> DUE TO <u>Bronchopneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Congenital Heart Disease</u> DUE TO <u>24 m.</u>
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Convulsive Disorder following Heart Surgery</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>5-12, 1959</u> , to <u>5-21, 1960</u> , that I last saw the deceased alive on <u>5-21, 1960</u> , and that death occurred at <u>MDAM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>David L. Weinstein</u> M.D. | | ADDRESS (Street, city or town, state) <u>3222 Davenport St NW</u> DATE <u>5-21-60</u> | |
| PHYSICIAN'S NAME (Type) <u>David L. Weinstein</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 22, 1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>MT. Lebanon Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danczowsky & Son</u> ADDRESS <u>3511 1st St NW Wash. D.C.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAY 24 '60</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u> | |

1934

OFFICE OF THE ATTORNEY GENERAL

2310

32

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05948

5939

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WISCONSIN b. COUNTY MILWAUKEE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
KENSINGTON | | | | c. LENGTH OF STAY IN 1b
30 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Kensington Gardens Rest Home | | | | d. STREET ADDRESS
2777 S. Shore Drive | | | |
| 3. NAME OF DECEASED (Type or print)
First OTTO Middle PAUL Last KETTNER | | | | 4. DATE OF DEATH
Month MAY Day 17 Year 19 60 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6/11/77 | |
| 9. AGE (In years last birthday) yrs.
82 | | 10. UNDER 1 YEAR
Months 24 Days 17 Hours 00 | | 11. UNDER 24 HRS.
Months 00 Days 00 Hours 00 Min. 00 | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrical Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
DuPont Company | | 11. BIRTHPLACE (State or foreign country)
Michigan | |
| 13. FATHER'S NAME
AUGUST KETTNER | | | | 14. MOTHER'S MAIDEN NAME
THERESA PETZOLD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
YES | | | | 16. SOCIAL SECURITY NO.
Spanish American 396-09-0458 | | 17. INFORMANT
Col. W. Dixon Smith, 11,800 Caplinger Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
334X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis
DUE TO (c) several years | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silver Spring | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/16/1960 to 5/17/1960 , that (I) (we) last saw the deceased alive on 5/17/1960 , and that death occurred on 5/17/1960 , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Donald Nelson | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/17/60 | |
| 22c. PHYSICIAN'S NAME (Type)
DONALD NELSON | | | | 22d. ADDRESS
10620 Georgia Ave. Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
TRANS. & BURIAL | | 23b. DATE THEREOF
5/20/60 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMETERY | | 23d. LOCATION (City, town, or county) (State)
MILWAUKEE, WISCONSIN | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Raymond E. Pompey, Inc. | | | | ADDRESS
SILVER SPRING, MD. | | 25a. REC'D BY REGISTRAR
MAY 20 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | | | | | |



5839

CERTIFICATE OF DEATH

DECEASED

NO. 1234

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

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6017

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05950

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)
c. LENGTH OF STAY IN 1b
27 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
District of Columbia
b. COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
2131 Observatory Place, N. W.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Herbert Middle Faulkner Last LARRICK | | | | 4. DATE OF DEATH
Month May Day 24 Year 1960 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-7-87 | |
| 9. AGE (In years lost birthday)
72 yrs. | | IF UNDER 1 YEAR
Months 72 Days 72 Hours 72 Min. | | IF UNDER 24 HRS.
Months 72 Days 72 Hours 72 Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U. S. Marine Corps | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
J. Buhrman LARRICK | | 14. MOTHER'S MAIDEN NAME
Cora RUDASILLE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WWI | | 17. INFORMANT
(B) Mr. Bernard Larrick, 2726 Conn. Ave. NW | | Address Washington, D. C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) 420.0 DUE TO
(c) 420.0 DUE TO
INTERVAL BETWEEN ONSET AND DEATH
8 years | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Rheumatoid Arthritis | | | | | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. 19 | | 20c. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20e. (City or town)
Washington | | 20f. (County)
District of Columbia | | 20g. (State)
District of Columbia | | 21. I certify that (I) John Wood Davis attended the deceased from April 27 19 60 , to May 24 19 60 , that (I) last saw the deceased alive on May 23 19 60 , and that death occurred at 6:15 am , from the causes and on the date stated above. | |
| 22a. SIGNATURE
John Wood Davis | | 22b. DATE SIGNED
5-24-60 | | 22c. PHYSICIAN'S NAME (Type)
John Wood DAVIS, LT, MC, USN | | 22d. ADDRESS
U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-27-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City, town, or county) (State)
Arlington Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Hysong Funeral Home | | 24a. ADDRESS
1300 N St., NW, Washington, DC | | 25a. REC'D BY REGISTRAR
MAY 26 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

CERTIFICATE OF DEATH

0011

00320

Department of Health

Washington

27 days

Residence (State)

5111 Observatory Place, N. W.

U. S. Naval Hospital

Division

Training

Medical

3-7-51

Occupation

Male

Virginia

U. S. Marine Corps

COOK HUBBARD

J. BARNETT BARNICK

Wife

Yes

(H) Mr. Barnett Barnick, also Civilian

April 21

1951

00

May 23

John Wood Davis, Jr., MD, PhD, U. S. Naval Hospital, Bethesda, Md.

Washington National

3-27-51

Male

Virginia

May 1951

May 1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05951

Reg. Dist. No.

5940

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>COLUMBIA</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>KENSINGTON</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WASHINGTON</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>KENSINGTON GARDENS NURSING HOME</u> | | | | d. STREET ADDRESS
<u>3140 WISCONSIN AVE., N. W.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MARY</u> Middle <u>W.</u> Last <u>LEET</u> | | | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>7</u> Year <u>1960</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>DEC. 6, 1871</u> | 9. AGE (In years last birthday)
<u>88</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>DOES NOT APPLY</u> | | 11. BIRTHPLACE (State or foreign country)
<u>WASHINGTON, D. C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>J. L. H. WINFIELD</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>JULIET TOWNSEND</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>HARVEY T. LEET, 1221 EYE ST., N.W., WASH. D.C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
<u>332X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u>
DUE TO (c) <u> </u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hrs</u>
<u>2 yrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>June 15, 1959</u> to <u>May 7, 1960</u> , that I last saw the deceased alive on <u>May 4, 1960</u> , and that death occurred at <u>11:10 AM</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Horace H. Custis Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1852 Columbia Rd NW, Washington 9 DC</u> | | | |
| DATE SIGNED
<u>May 9 '60</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>5-10-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>ROCK CREEK CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>WASHINGTON, D. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Joseph Shewler's Sons</u> | | | | ADDRESS
<u>1756 Pa Ave Wash DC</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 9 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Carlton S. Hanna</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6019

Item 14 Film G262 5/11/60 iwk

CERTIFICATE OF DEATH

05953

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>1 1/2 da.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Meredith Clyde Lentz</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>6</u> Year <u>19 60</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 6 1916</u> | 9. AGE (In years last birthday) <u>44</u> yrs. | IF UNDER 1 YEAR
Months <u>4</u> Days <u>0</u> | IF UNDER 24 HRS.
Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Insurance Broker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penn.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | 13. FATHER'S NAME <u>Joseph Lentz</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Mae Kerstetter</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>Unknown</u> | | | | 17. INFORMANT <u>Vernice Lentz, same address</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma, lung</u>
DUE TO (b) <u>Cerebral metastases</u>
DUE TO (c) <u>Pulmonary edema</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 2 years 1 week 24 hours</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>June 5-6</u> , 19 <u>58</u> to <u>May 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-6</u> , 19 <u>60</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Philip R. James</u> | | | | ADDRESS (Street, city or town, state) <u>Washington Clinic, D.C.</u> DATE SIGNED <u>5/6/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Philip R. James</u> | | | | M.D. <u>Washington Clinic, D.C.</u> | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Transit Burial</u> | | <u>5/9/60</u> | | <u>East Petersburg Cem</u> | | <u>Lancaster, Pennsylvania</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAY 9 1960</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

1. Name of deceased *John Doe*
2. Sex *Male*
3. Age *45*
4. Date of death *Jan 15 1918*
5. Place of death *Home*
6. Cause of death *Heart Disease*
7. Signature of physician *J. H. Smith*
8. Signature of registrar *W. B. Jones*
9. Signature of informant *M. E. Doe*
10. Date of registration *Jan 16 1918*

11. Name of informant *M. E. Doe*
12. Address of informant *123 Main St, City, State*
13. Name of registrar *W. B. Jones*
14. Address of registrar *456 Main St, City, State*
15. Name of physician *J. H. Smith*
16. Address of physician *789 Main St, City, State*
17. Name of informant *M. E. Doe*
18. Address of informant *123 Main St, City, State*
19. Name of registrar *W. B. Jones*
20. Address of registrar *456 Main St, City, State*
21. Name of physician *J. H. Smith*
22. Address of physician *789 Main St, City, State*
23. Name of informant *M. E. Doe*
24. Address of informant *123 Main St, City, State*
25. Name of registrar *W. B. Jones*
26. Address of registrar *456 Main St, City, State*
27. Name of physician *J. H. Smith*
28. Address of physician *789 Main St, City, State*
29. Name of informant *M. E. Doe*
30. Address of informant *123 Main St, City, State*
31. Name of registrar *W. B. Jones*
32. Address of registrar *456 Main St, City, State*
33. Name of physician *J. H. Smith*
34. Address of physician *789 Main St, City, State*
35. Name of informant *M. E. Doe*
36. Address of informant *123 Main St, City, State*
37. Name of registrar *W. B. Jones*
38. Address of registrar *456 Main St, City, State*
39. Name of physician *J. H. Smith*
40. Address of physician *789 Main St, City, State*
41. Name of informant *M. E. Doe*
42. Address of informant *123 Main St, City, State*
43. Name of registrar *W. B. Jones*
44. Address of registrar *456 Main St, City, State*
45. Name of physician *J. H. Smith*
46. Address of physician *789 Main St, City, State*
47. Name of informant *M. E. Doe*
48. Address of informant *123 Main St, City, State*
49. Name of registrar *W. B. Jones*
50. Address of registrar *456 Main St, City, State*
51. Name of physician *J. H. Smith*
52. Address of physician *789 Main St, City, State*
53. Name of informant *M. E. Doe*
54. Address of informant *123 Main St, City, State*
55. Name of registrar *W. B. Jones*
56. Address of registrar *456 Main St, City, State*
57. Name of physician *J. H. Smith*
58. Address of physician *789 Main St, City, State*
59. Name of informant *M. E. Doe*
60. Address of informant *123 Main St, City, State*
61. Name of registrar *W. B. Jones*
62. Address of registrar *456 Main St, City, State*
63. Name of physician *J. H. Smith*
64. Address of physician *789 Main St, City, State*
65. Name of informant *M. E. Doe*
66. Address of informant *123 Main St, City, State*
67. Name of registrar *W. B. Jones*
68. Address of registrar *456 Main St, City, State*
69. Name of physician *J. H. Smith*
70. Address of physician *789 Main St, City, State*
71. Name of informant *M. E. Doe*
72. Address of informant *123 Main St, City, State*
73. Name of registrar *W. B. Jones*
74. Address of registrar *456 Main St, City, State*
75. Name of physician *J. H. Smith*
76. Address of physician *789 Main St, City, State*
77. Name of informant *M. E. Doe*
78. Address of informant *123 Main St, City, State*
79. Name of registrar *W. B. Jones*
80. Address of registrar *456 Main St, City, State*
81. Name of physician *J. H. Smith*
82. Address of physician *789 Main St, City, State*
83. Name of informant *M. E. Doe*
84. Address of informant *123 Main St, City, State*
85. Name of registrar *W. B. Jones*
86. Address of registrar *456 Main St, City, State*
87. Name of physician *J. H. Smith*
88. Address of physician *789 Main St, City, State*
89. Name of informant *M. E. Doe*
90. Address of informant *123 Main St, City, State*
91. Name of registrar *W. B. Jones*
92. Address of registrar *456 Main St, City, State*
93. Name of physician *J. H. Smith*
94. Address of physician *789 Main St, City, State*
95. Name of informant *M. E. Doe*
96. Address of informant *123 Main St, City, State*
97. Name of registrar *W. B. Jones*
98. Address of registrar *456 Main St, City, State*
99. Name of physician *J. H. Smith*
100. Address of physician *789 Main St, City, State*

6020

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b
12 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
d. STREET ADDRESS 1 5929 Avon Drive
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HENRY Middle A. Last LINGER | | 4. DATE OF DEATH
Month MAY Day 25 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/27/75 |
| 9. AGE (In years last birthday) 84 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired owner furniture store | | 10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Linger, Sr. | | 14. MOTHER'S MAIDEN NAME ---Kuhland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT
Bessie M. Linger Address same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
3322X DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) CEREBRAL ARTERIOSCLEROSIS
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEART BLOCK. - INCOMPLETE
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May , 19 58 , to May 25 , 19 60 , that I last saw the deceased alive on May 24 , 19 60 , and that death occurred at 5:20 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 10609 CONCORD ST. WASHINGTON, MD. DATE SIGNED 5-25-60 | | | |
| ACTUAL SIGNATURE Robert T. Thibadeau | | PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU KENSINGTON, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 5/28/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Suitland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington 9, D.C. | | 24a. REC'D BY REGISTRAR DATE MAY 26 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

1 **B**

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

0

BP

VS AIS (4)
15M 9/58

12



6021

CERTIFICATE OF DEATH

05955
Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland
b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
44 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
9200 Wisconsin Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First MARY Middle BAPTIST Last LOOKETT | | 4. DATE OF DEATH
Month May Day 29 , Year 19 60 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1877
Aug. 10, 1878 |
| 9. AGE (In years last birthday)
81 1/2 yrs. | | 10. IF UNDER 1 YEAR
Months 9 Days 19 Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11b. KIND OF BUSINESS OR INDUSTRY
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | 13. FATHER'S NAME
Edward Langston Baptist | |
| 14. MOTHER'S MAIDEN NAME
Emily Rolfe | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No
(If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO.
Yes | | INFORMANT Son
Edward B. Lockett | |
| 17. ADDRESS
4407 Klingle St., N.W.
Washington, D. C. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory Failure.
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerosis.
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post OPERATIVE Hip ARTHRODESIS | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from January , 19 60 , to May 29 , 19 60 that I last saw the deceased alive on May 28 , 19 60 , and that death occurred at 7:10 PM , from the causes and on the date stated above. | |
| ACTUAL SIGNATURE Donald Q. Ekman M.D. 5207 Wisconsin Ave | | DATE SIGNED 5/29/60 | |
| PHYSICIAN'S NAME (Type) DONALD Q. EKMAN | | 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial-transit 5-31-60 | |
| 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
Presbyterian Cemetery | |
| 22d. LOCATION (City, town, or county) (State)
Boydton, Virginia. | | 23. FUNERAL DIRECTOR'S SIGNATURE
ROBERT A. PUMPHREY | |
| ADDRESS
Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 1 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kross | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

44

1934

Montgomery

Montgomery

1125 1/2

1125 1/2

9200 Wisconsin Ave.

9200 Wisconsin Ave.

MARY E. BAPTIST BOOKLET

Aug. 13, 1934

Wm. H. H. H.

Virginia

Virginia

Edward Harrison Hopkins

Emily Kelle

Yes

Wm. H. H. H.

Wm. H. H. H.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit (File in case 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.)

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5946

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05956

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>monty</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | c. LENGTH OF STAY IN lb
<u>life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> (<u>rural</u>) | | d. STREET ADDRESS
<u>Norwood Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Norwood Rd.</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
<u>Nelson Lomax</u> | | | | 4. DATE OF DEATH
<u>5-17</u> 19 <u>60</u> | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>col</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9-23-1887</u> | |
| 9. AGE (In years last birthday)
<u>72</u> yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>labour</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>md</u> | | 11. BIRTHPLACE (State or foreign country)
<u>n.s.c.</u> | |
| 13. FATHER'S NAME
<u>Wm Lomax</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Louise Helmer</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>Gray Lomax</u> | | 17. INFORMANT
<u>Stum 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>
Conditions, if any, which gave rise to immediate cause (b) <u></u> DUE TO <u></u>
(e), stating the underlying cause last. (c) <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been ill for 3 or 4 day when found</u>
INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED <u>5-17-60</u> | | | |
| | | | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) (State) | |
| <u>Burial</u> | | <u>5/19/60</u> | | <u>Mt. Pleasant.,</u> | | <u>Norbeck, Md.</u> | |
| 23. FUNERAL DIRECTOR
<u>Robert L. Snowden</u> | | | | ADDRESS
<u>Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 25 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hines</u> | | | |

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

6022

CERTIFICATE OF DEATH

05957

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
GERMANTOWN | | | | c. LENGTH OF STAY IN 1b
12 ROCKVILLE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MARYLANDER NURSING HOME | | | | d. STREET ADDRESS
12,115 Hunters Lane | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First LOUISE Middle B Last LONG | | | | 4. DATE OF DEATH
Month MAY Day 15 Year 19 60 | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6/19/92 | | 9. AGE (In years lost birthday) yrs.
67 | IF UNDER 1 YEAR
Months
Days
Hours
Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
BENJAMIN CRANFORD | | | | 14. MOTHER'S MAIDEN NAME
MARY E. HOOK | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | INFORMANT Address
Mr. John C. Long, Sr.
12,115 Hunters Lane, Rockville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
2 MONTHS
6 WEEKS | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-11, 1960 , to 5-15, 1960 , that I last saw the deceased alive on 5-14, 1960 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
W. G. Hall | | ADDRESS (Street, city or town, state) DATE SIGNED
615 W. MONTGOMERY AVE. ROCKVILLE, MD. 5/15/60 | | | | | |
| PHYSICIAN'S NAME (Type)
W. G. HALL | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
5/18/60 | | 22c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN CEMETERY | | 22d. LOCATION (City, town, or county) (State)
MONTGOMERY COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
WAGNER E. PLUMDREY, INC.
Raymond W. Ziska | | | | ADDRESS
SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR
DATE MAY 17 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

6033



1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5927
CERTIFICATE OF DEATH

05958

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase
c. LENGTH OF STAY IN 1b
55
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
5205 Chamberlin Avenue | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase
d. STREET ADDRESS
5205 Chamberlin Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Katherine Loughran | | 4. DATE OF DEATH
Month Day Year
May 31 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 15, 1886 |
| 9. AGE (In years last birthday)
73 yrs. | | IF UNDER 1 YEAR: Months Days Hours
IF UNDER 24 HRS: Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Daniel Loughran | | 14. MOTHER'S MAIDEN NAME
Mary Fitzgerald | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Regina L. Carley (Sister)
5205 Chamberlin Ave., Chevy Chase Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 190.9 Malignant Melanoma
DUE TO (b) General Abdominal Metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month Day Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/2/1939 to 5/31/1960 , that (I) (we) last saw the deceased alive on 5/31/1960 and that death occurred on 5/31/1960 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Lyda M. Lyda | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
LYDA M. LYDA | | 22d. ADDRESS
3066 - Quaker - Mt. Airy - Wash. D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6-3-1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State)
Washington, D. C. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Joseph Gawler & Sons, Inc. 1756 Pa. Ave. N.W. Wash. D.C. | | 25a. REC'D BY REGISTRAR
JUN 3 '60 | |
| 25b. REGISTRAR'S SIGNATURE
Charles E. Harris | | | |

55

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, at the City of Dallas, this 1st day of May, 1901.

Attest:

County Clerk

My Comm. Expires

May 1, 1902

Witness my hand and the seal of said County, at the City of Dallas, this 1st day of May, 1901.

County Clerk

My Comm. Expires

May 1, 1902

Witness my hand and the seal of said County, at the City of Dallas, this 1st day of May, 1901.

County Clerk

My Comm. Expires

May 1, 1902

Witness my hand and the seal of said County, at the City of Dallas, this 1st day of May, 1901.

County Clerk

My Comm. Expires

May 1, 1902

Witness my hand and the seal of said County, at the City of Dallas, this 1st day of May, 1901.

County Clerk

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | |
|--|--|--|--|--|--|--------------------------------------|--|
| a. COUNTY | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS | |
| Montgomery | | Silver Spring | | 28 Silver Spring | | 2201 Ruminary Rd | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First Middle Last | | | | Month Day Year | | | |
| William Franklin Mahon | | | | May 20 1960 | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| Male | | White | | 7-30-'48 | | 11 yrs. | |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| School boy | | | | D.C. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Wilbur Francis Mahon | | | | Martha Greening | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| no | | | | none | | | |
| 15. INFORMANT | | | | Address | | | |
| Wilbur Mahon - | | | | Stim 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage due to compound injury to left chest | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Amputation of left Thigh | | | | | | | |
| (c) falling tree | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | |
| Compound fracture of leg | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| Was standing in path of a falling tree | | | | | | | |
| 20c. TIME OF INJURY | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| Month, Day, Year | | While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | | Woods | | Silver Spring Montg Md | |
| Hour | | 5-20 1960 | | 4:25 p.m. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| FRANK J. Broschart | | | | DATE SIGNED | | | |
| 5-20-60 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 22b. DATE THEREOF | | | |
| BURIAL | | | | 5/23/60 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY | | | | 22d. LOCATION (City, town, or country) (State) | | | |
| ROCK CREEK CEMETERY | | | | WASHINGTON, D.C. | | | |
| 23. FUNERAL DIRECTOR | | | | 24a. REC'D BY REGISTRAR | | | |
| WAGNER E. PUMPHREY, INC. | | | | 24b. REGISTRAR'S SIGNATURE | | | |
| Raymond A. Ziska | | | | DATE MAY 24 '60 | | | |
| SILVER SPRING, MD. | | | | Arthur S. Kraus | | | |

(M)
28

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

6023

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05960

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓
a. STATE New Jersey b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
23 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Newark | |
| 3. NAME OF DECEASED (Type or print)
First Nathan Middle Theodore Last Maloratsky | | 4. DATE OF DEATH
Month May Day 31 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
February 26, 1920 |
| 9. AGE (In years lost birthday) yrs.
40 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY
Trucking | |
| 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Joseph Maloratsky | | 14. MOTHER'S MAIDEN NAME
Yetta Funt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
136-12-0630 | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
41 <input checked="" type="checkbox"/> DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.
(b) Rheumatic heart disease
DUE TO
(c) Mitral & Aortic insufficiency
INTERVAL BETWEEN ONSET AND DEATH
immediate
30 years
30 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 8, 1960 to May 31, 1960 , that (I) (we) last saw the deceased alive on May 31, 1960 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>E. Kent Carney</i> | | 22b. DATE SIGNED
5/31/60 | |
| 22c. PHYSICIAN'S NAME (Type)
E. Kent Carney, M.D. | | 22d. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
JUNE 1-1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY
HEBREW CEM. NEWARK, N.J. | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>B. Langansky & Sons, WASH, DC</i> | | 25a. REC'D BY REGISTRAR
JUN 2 '60 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. House</i> | | | |

DEPARTMENT OF HEALTH
CITY OF NEW YORK
BUREAU OF VITAL STATISTICS
BIRTH RECORD

6023

10

1

5932

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montg MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montg, | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg | | c. LENGTH OF STAY IN 1b
47Yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First George Middle Elwood Last Marshall | | 4. DATE OF DEATH
Month May Day 30 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Apr 25-15-13 |
| 9. AGE (In years lost birthday)
47 yrs. | | 10. IF UNDER 1 YEAR
Months 1 Days 13 | 11. IF UNDER 24 HRS.
Hours 13 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Government Clerk. | | 10b. KIND OF BUSINESS OR INDUSTRY
Gaithersburg, Md. | |
| 11. BIRTHPLACE (State or foreign country)
U S A | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
George W. Marshall | | 14. MOTHER'S MAIDEN NAME
Mary Dwyer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
W.W.2 217-18-7638 | |
| 17. INFORMANT
Betty U. Marshall. | | Address 16 Montg, Ave, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis i.e. lung
153.8 DUE TO liver, intra-abdominal viscera
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma - colon
(c) 3 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Apr. , 19 60 , to May 30, 1960 , that I last saw the deceased alive on May 29 , 19 60 , and that death occurred at 2:58 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 105 Russell Ave., Gaithersburg, Md. DATE SIGNED 5-30-60
ACTUAL SIGNATURE Jack Schumacher
PHYSICIAN'S NAME (Type) Jack Schumacher | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6-1-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Forest Oak | | 22d. LOCATION (City, town, or county) (State)
Gaithersburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ernest C. Gartner. | | 24a. REC'D BY REGISTRAR
DATE JUN 1 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Hines | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

6024

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05962

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN 1b
130 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital | | | | d. STREET ADDRESS
1104 21st Place, N. E. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Roscoe Middle Woodrow Last MC CALL | | | | 4. DATE OF DEATH
Month May Day 15 Year 1960 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-10-18 | |
| 9. AGE (In years last birthday)
41 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
So. Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Bennie MC CALL | | | | 14. MOTHER'S MAIDEN NAME
Rosa WATSON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)
Yes 1944 - 1946 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Testicular carcinoma
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the lung DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
1 yr | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. _____ p. m. _____
Month _____ Day _____ Year 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) physician attended the deceased from January 6, 1960 to May 15, 1960 , that (I) yes last saw the deceased alive on May 14, 1960 , and that death occurred at 6:20 am , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Robert C. Thomas | | | | 22b. DATE
5-16-60 | | 22c. PHYSICIAN'S NAME (Type)
Robert C. THOMAS, LT, MC, USN | |
| 22d. ADDRESS
U. S. Naval Hospital, Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial-Shipment | | 23b. DATE THEREOF
5-18-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Darlington S.C. | | 23d. LOCATION (City, town, or county) _____ (State) _____ | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W.E. Jarvis Funeral Home, 1432 U St., NW, WashDC | | | | 25a. REC'D BY REGISTRAR
MAY 19 '60 | | 25b. REGISTRAR'S SIGNATURE
Charles S. Thomas | |

6024

CENTRAL DE DATA

11-003



Director of Columbia

Washington

Washington

150 days

1104-2104 Project, N. A.

U. S. Naval Hospital

NO CALL

NO CALL

NO CALL

NO CALL

12-10-12

12-10-12

NO CALL

NO CALL

NO CALL

NO CALL

NO CALL

NO CALL

NO CALL

NO CALL



11-003

January 6 1960

January 6 1960

11-003

Report of THOMAS, M. NO, U.S. Naval Hospital, Bethesda, Md.

U.S.

U.S.

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6025 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05963

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Summer</u> | | c. LENGTH OF STAY IN lb
<u>3 mo</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Summer</u> | | d. STREET ADDRESS
<u>4802 Ft. Summer Dr. Wash 16, DC</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>4802 Ft. Summer Dr. Wash 16, DC</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
<u>Brian Paul McClinton</u> | | 4. DATE OF DEATH
<u>May 21 1960</u> | | 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>6-2-1959</u> | | 9. AGE (in years last birthday)
<u>11</u> yrs. | | IF UNDER 1 YEAR
Months <u>11</u> Days <u>19</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>—</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Morocco - Ind.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.C.</u> | |
| 13. FATHER'S NAME
<u>Stephen McClinton</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Dorothy Groesbeck</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>Stephen McClinton - (father)</u> <u>John 2</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia</u>
<u>924.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Strangulation</u>
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Neck was caught between sides of hinged top of crib</u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>3:45 p.m. 5-21-60</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | 20f. (City or town) (County) (State)
<u>Summer Montg md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>Frank J. Boschert</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
<u>FRANK J. BOSCHERT</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED
<u>5-21-60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5-24-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Natl. Cem</u> | | 22d. LOCATION (City, town, or country) (State)
<u>Arlington Va</u> | |
| 23. FUNERAL DIRECTOR
<u>W. Don. DeVol</u> | | | | 24a. REC'D BY REGISTRAR
<u>2224 Wisconsin Ave</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Carlton S. Kline</u> | |

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100-100

57

1

100-100

COSS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11/10/1917
I, the undersigned, being a duly qualified Medical Examiner, do hereby certify that on the 11th day of November 1917, at the residence of the deceased, I examined the body of
[Name of Deceased]
and found that the cause of death was
[Cause of Death]
and that the death was due to natural causes.
Witness my hand and the seal of my office this 11th day of November 1917.
[Signature of Medical Examiner]
[Seal of Medical Examiner]
100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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073
6026
DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05964

| | | | | | | | |
|---|---------------------------|--|-----------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
OLNEY
c. LENGTH OF STAY IN 1b
25 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MONTGOMERY COUNTY GENERAL HOSPITAL | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
HOWARD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WOODBINE
d. STREET ADDRESS
13X-2
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First
MARY
Middle
GEES
Last
MCCOMAS | | 4. DATE OF DEATH
Month
MAY
Day
4
Year
1960 | | | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/25/04 | 9. AGE (In years last birthday)
55 yrs. | IF UNDER 1 YEAR
Months
Days
Hours
Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DISTRIBUTOR | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | |
| 12. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 13. FATHER'S NAME
WILLIAM GEES MCCOMAS | | 14. MOTHER'S MAIDEN NAME
MARY EDNA STAUFFER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
HOSPITAL RECORDS, OLNEY, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CACHEXIA
158X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) MELANOCARCINOMA OF OMENTUM WITH METASTASES TO
DUE TO
(c) BRAIN, LUNGS, KIDNEYS AND LIVER
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from SEPT. 1959 to MAY 4, 1960 that (I) (we) last saw the deceased alive on MAY 4, 1960, and that death occurred at 9:30 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Charles S. Whitaker | | 22b. DATE
5 May 1960 | | 22c. PHYSICIAN'S NAME (Type)
CHARLES S. WHITAKER, M. D. | | | |
| 22d. ADDRESS
CLARKSVILLE, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
5-9-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory | | | |
| 23d. LOCATION (City, town, or county)
Washington, D. C. | | (State) | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland | | 25a. REC'D BY REGISTRAR
DATE MAY 9 '60 | | 25b. REGISTRAR'S SIGNATURE
Charles S. Howard | | | |

100

6027

CERTIFICATE OF DEATH

Reg. Dist. No.

05965

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>FAIRLAND</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bellville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>FAIRLAND NURSING Home</u> | | d. STREET ADDRESS
<u>4615 Powder Mill Rd</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>OLIVE</u> Middle <u>O.</u> Last <u>MCCORD</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>5</u> Year <u>1960</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan 31, 1886</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>7</u> Days <u>4</u> Hours <u>1</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Government worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Government</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Samuel Clayton</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Gale</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>INFORMANT</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>
DUE TO (c) <u>General arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>2 years</u>
<u>40 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Diabetes mellitus</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 5, 1948</u> to <u>May 5, 1960</u> , that I last saw the deceased alive on <u>May 5, 1960</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Hans Wodak</u> | | ADDRESS (Street, city or town, state)
<u>9-E PARKWAY, GREENBELT, MD 56-60</u> | |
| PHYSICIAN'S NAME (Type)
<u>HANS WODAK, M.D.</u> | | DATE SIGNED
<u>May 11 '60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>5-9-60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Cem.</u> | 22d. LOCATION (City, town, or county) (State)
<u>Bladensburg Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W.W. Chambers Co</u> | | 24a. REGISTRY SIGNATURE
<u>Arthur L. Hines</u> | |

74

CERTIFICATE OF DEATH

Reg. Dist. No.

05966

5911

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
o. STATE <u>Dist. of Col.</u> b. COUNTY <u>Dist. of Col.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dist. of Col. North East</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | | | e. STREET ADDRESS <u>5721 N. Capitol St., N.E.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Malissa</u> First <u>Stella</u> Middle <u>McDevitt</u> Last | | | | 4. DATE OF DEATH <u>May</u> Day <u>7</u> Year <u>19 60</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 6, 1960</u> | |
| 9. AGE (In years last birthday) <u>0</u> yrs. | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>14</u> Min. <u>0</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | | |
| 13. FATHER'S NAME <u>Thomas Bernard McDevitt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Gaye Sherri Bolitho</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>mother</u> Address <u>5721 N. Capitol St., N.E.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
<u>773.5</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post maturity</u>
DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21. I certify that I attended the deceased from <u>11:45, May 6, 19 60</u> , to <u>1:45 May 7, 19 60</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>60</u> , and that death occurred at <u>1:45 a. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>927 Pershing Drive</u> | | DATE SIGNED <u>5/7/60</u> | |
| PHYSICIAN'S NAME (Type) <u>Winston E. Cochran</u> | | | | <u>Silver Spring, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 10, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Cresswell St. NW</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAY 10 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5/6/60 2075231XV5

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| DECEASED
NAME
LAST FIRST MIDDLE
SEX
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
MARITAL STATUS
COLOR
RELIGION
EDUCATION
SERVICE
GRADE
BRANCH
COMPANY
REGIMENT
DIVISION
CORPS
SERVICE NUMBER
GRADE
BRANCH
COMPANY
REGIMENT
DIVISION
CORPS
SERVICE NUMBER | | PLACE OF DEATH
STREET
CITY
COUNTY
STATE
ZIP CODE
DATE OF DEATH
TIME OF DEATH
PLACE OF DEATH
STREET
CITY
COUNTY
STATE
ZIP CODE | |
| CAUSE OF DEATH
1. IMMEDIATE
2. INTERMEDIATE
3. UNDERLYING
4. MANNER OF DEATH
5. MANNER OF DEATH
6. MANNER OF DEATH
7. MANNER OF DEATH
8. MANNER OF DEATH
9. MANNER OF DEATH
10. MANNER OF DEATH | | SIGNATURE OF PHYSICIAN
NAME
ADDRESS
CITY
COUNTY
STATE
ZIP CODE
DATE
TIME | |
| SIGNATURE OF REGISTRAR
NAME
ADDRESS
CITY
COUNTY
STATE
ZIP CODE
DATE
TIME | | SIGNATURE OF WITNESS
NAME
ADDRESS
CITY
COUNTY
STATE
ZIP CODE
DATE
TIME | |

This certificate is to be filled out by the physician or other qualified person who has attended the deceased.
 It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the State Department of Health.
 The information furnished on this certificate is for the purpose of compiling statistics and for the purpose of determining the cause of death.
 It is not to be used for any other purpose.
 The information furnished on this certificate is for the purpose of compiling statistics and for the purpose of determining the cause of death.
 It is not to be used for any other purpose.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6028 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05967

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
OLNEY
c. LENGTH OF STAY IN 1b
4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
MONTGOMERY COUNTY GENERAL HOSPITAL | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
ROCKVILLE
d. STREET ADDRESS
FALLS ROAD
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
BERNARD LEO MCGOWAN | | 4. DATE OF DEATH
Month Day Year
MAY 10 19 60 | | 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/28/03 | | 9. AGE (In years last birthday)
57 yrs. | | IF UNDER 1 YEAR
Months Days
57 | | IF UNDER 24 HRS.
Hours Min.
57 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WINDOW CLEANER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
MARYLAND | | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
JAMES MCGOWAN | | | | 14. MOTHER'S MAIDEN NAME
MARTHA HAINES | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
I | | | | 16. SOCIAL SECURITY NO.
HOSPITAL RECORDS, OLNEY, MARYLAND | | | | 17. INFORMANT
Address
HOSPITAL RECORDS, OLNEY, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL ANEURYSM, SUDDEN
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) 451X
(c) DIED UNDER ANESTHESIA WHILE DOING AN EXPLORATORY OPERATION
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Frank J. Broschart M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) FRANK J. BROSCART, M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/10/60
Address (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
5-14-60 | | 22c. NAME OF CEMETERY OR CREMATORY
Samples Manor | | | | 22d. LOCATION (City, town, or country) (State)
Washington County, Md. | | | | | | | | | |
| 23. FUNERAL DIRECTOR
ADDRESS
Thomas H. Barber Laytonsville, Md. | | | | | | | | 24a. REC'D BY REGISTRAR
DATE MAY 13 '60 | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thoms | | | | | | | |

6032

100 2718



MONTGOMERY COUNTY GENERAL HOSPITAL

4 DAYS

MONTGOMERY COUNTY GENERAL HOSPITAL

WHITE
MONTGOMERY COUNTY GENERAL HOSPITAL
JANUARY 1, 1950
FALLS ROAD
KOCVILLE
MONTGOMERY

INDIAN CLEAR

MARYLAND

JAMES MCGOWAN

MARYLAND

HOSPITAL RECORDS

DEATH RECORDS

DIED UNDER ANESTHESIA WHILE DOING AN EXPLORATORY OPERATION

FRANK J. BROCKHART, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05968

5912

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> | | | | c. LENGTH OF STAY IN 1b <u>16 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u> | | | | d. STREET ADDRESS <u>11432 Schuykill Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph FRANK McJilton</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1960</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1/9/87</u> | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | 13. FATHER'S NAME <u>Thomas T. McJilton</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Molly Moffett</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <u>Pt's Hosp. Record</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Stroke</u>
4500 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cerebral Arteriosclerosis</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>
<u>undetermined</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that (I) (this hospital) attended the deceased from <u>4-27-60</u> , 19 <u>60</u> , to <u>5-13</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>60</u> , and that death occurred at <u>11:25</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Morris Perry</u> | | | | 22b. DATE SIGNED <u>5-13-60</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u> | | | | 22d. ADDRESS <u>11602 Georgia Avenue, Star Spring Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/16/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u> | | 23d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler - Rockville, Ind.</u> ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE <u>MAY 16 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

2012

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6029

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05969

Reg. Dist. No.

| | | | | | |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b
6 mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Congressional Manor San. | | | d. STREET ADDRESS
6822 Wilson La. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Archabold Middle A. Last McKinley | | | 4. DATE OF DEATH
Month May Day 8 Year 19 60 | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/16/1871 | 9. AGE (in years last birthday)
88 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Attorney | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired Lawyer | | 11. BIRTHPLACE (State or foreign country)
Iowa | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
John McKinley | | |
| 14. MOTHER'S MAIDEN NAME
McNamara | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | |
| 16. SOCIAL SECURITY NO.
None | | | 17. INFORMANT
San. Records Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
153.7 IMMEDIATE CAUSE (a) Carcinoma of lower intestinal tract with metastasis
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____
DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 yr. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
May 8, 1960 | |
| EXAMINER'S NAME (Type)
Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-10-60 | | 22c. NAME OF CEMETERY OR CREMATORY
All Saints, Cemetery | |
| 22d. LOCATION (City, town, or county)
DesPlaines | | (State)
Ill. | | 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | |
| 24a. REC'D BY REGISTRAR
DATE MAY 10 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Huns | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15970

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b
28 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Beatrice Middle Worthington Last MC KINNIS | | | | 4. DATE OF DEATH
Month May Day 23 Year 19 60 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-30-70 | 9. AGE (In years last birthday)
40 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- - - - - | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
William COLBERT | | | | 14. MOTHER'S MAIDEN NAME
Ella STANBURY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
- - - - - | | 17. INFORMANT
(H) Charles T. McKinnis, same as #2 above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Leukemia, acute, type undetermined
204.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 mos |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY
Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 25 19 60 to May 23 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 23 19 60 , and that death occurred at 4:28AM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>F. S. Caldwell</i> | | | | 22b. DATE SIGNED
5-23-60 | | 22c. PHYSICIAN'S NAME (Type)
F. S. CALDWELL, LT, MC, USN | |
| 22d. ADDRESS
U. S. Naval Hospital, Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| Burial | | 5-27-1960 | | Brewer Hill | | Annapolis Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Wm. Reese Mortuary</i> | | | | ADDRESS
Annapolis, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 26 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Frank</i> | | | |

CERTIFICATE OF DEATH

10000

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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6031
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05971

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Mont. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b
1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Leroy Middle Arthur Last MC MULLEN | | | | 4. DATE OF DEATH
Month May Day 23 Year 1960 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-8-89 | |
| 9. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Guard | | 10b. KIND OF BUSINESS OR INDUSTRY
Power Co. | |
| 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Solomon MC MULLEN | | | | 14. MOTHER'S MAIDEN NAME
Clarisa SABIN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WWI | | 17. INFORMANT
Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, prostate with metastasis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
7 yrs. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 22 19 60 to May 23 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 23 19 60 , and that death occurred on 8:15 am from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
L. S. Irons | | | | 22b. DATE SIGNED
5-23-60 | | | |
| 22c. PHYSICIAN'S NAME (Type)
L. S. IRONS LT MC USN | | | | 22d. ADDRESS
U. S. Naval Hospital, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/26/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City, town, or county) (State)
Arlington Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lee Funeral Home, 4th & Mass. Ave., N.W., WashDC | | | | 25a. REC'D BY REGISTRAR
MAY 25 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Irons | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05972

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|--------------------------------------|---|---|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
59 Bethesda | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hosp. | | | | d. STREET ADDRESS
7513 Marbury Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
A.C. Miller a/k/a Amos C. Miller | | | | 4. DATE OF DEATH
Month May Day 12 Year 1960 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/14/1884 | | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
retired | | 11. BIRTHPLACE (State or foreign country)
Ind. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Jos. P. Miller | | | | 14. MOTHER'S MAIDEN NAME
Martha Wortinger | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Morris V. Boley | | Address
Item 2 Son in law | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertention
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
sudden

years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)
C.V.A. about 6 mo. ago | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL PERMIT NO.
5-16-60 | | | | 22b. DATE THEREOF
5-16-60 | | 22c. NAME OF CEMETERY OR CREMATORY.
Ft Lincoln Cem, | |
| 22d. LOCATION (City, town, or county)
Colmar Manor, Md. | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. William Lee's Sons Co | | | | ADDRESS
300-4th St. N.E. | | 24a. REC'D BY REGISTRAR
MAY 16 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6033

CERTIFICATE OF DEATH

05973

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
X | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
8804 Mead Street | | | | d. STREET ADDRESS
8804 Mead Street | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
CORA | | First MAE Middle MILLER Last | | 4. DATE OF DEATH
MAY 9 1960 | | Month 9 Day 1960 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1877 May 6, 1887 | 9. AGE (In years last birthday)
83 yrs. | IF UNDER 1 YEAR
Months 0 Days 3 | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
NR US | |
| 13. FATHER'S NAME
Daniel Dority | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Ward Miller, Jr. -son-same as 2d | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 42211
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from MAY 12 1959 to MAY 9 1960 , that (I) last saw the deceased alive on MAY 8 1960 , and that death occurred at 12:03 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
DeWitt E. DeLauter | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
DEWITT E. DELAUTER M.D. | | | | 22d. ADDRESS
8025 ABERDEEN RD. Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Bur-Transit | | 23b. DATE THEREOF
5/10/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Ilion Cemetery | | 23d. LOCATION (City, town, or county) (State)
Ilion, New York | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Robert A. Pumphrey Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
MAY 10 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Haines | |

CERTIFICATE OF DEATH

0023

Monterey

Married

Monterey

Bethesda

Bethesda

8800 Reed Street

8800 Reed Street

Mr.

Walter

Walter

Walter

May 6, 1917

Walter

MS 12

New York

Monterey

Bethesda

Walter

Walter Miller, Jr. - son - name as is

Walter

MS

Walter Miller, Jr. - son - name as is

Robert A. Pugh, Bethesda, Maryland

Walter, New York

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6034

05974

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)
c. LENGTH OF STAY IN 1b 16 days | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 5500 Parkland Ct., S.E.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) William Jacob MILLER | | | | 4. DATE OF DEATH
Month May Day 25 Year 1960 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10-3-83 | |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | | IF UNDER 24 HRS.
Months _____ Days _____ Hours _____ Min. _____ | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Officer | |
| 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Marine Corps | | 11. BIRTHPLACE (State or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Ludwig MILLER | | | | 14. MOTHER'S MAIDEN NAME
Susannah BOOSE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) Yes 1907-1938 & 1942-1945 | | 16. SOCIAL SECURITY NO.
578-50-9000 | | 17. INFORMANT
(S) Mrs. Katherine Simons, Box 318, Michigan | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma, colon, with metastasis
153.8 DUE TO _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (Monson) attended the deceased from May 9 1960 to May 25 1960, that (I) (x) last saw the deceased alive on May 25 1960, and that death occurred at 9:29 PM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Barclay M. Shepard | | | | 22b. DATE SIGNED
5-26-60 | | 22c. PHYSICIAN'S NAME (Type)
Barclay M. SHEPARD, LT, MC, USN | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
5-31-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | |
| 23d. LOCATION (City, town, or county)
Arlington | | | | 23e. (State)
Virginia | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lee Funeral Home, 4th & Mass. Ave., NW, WashDC | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kline | |

M

051

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1

STATE OF NEW YORK

0034

Division of Columbia

Washington

10 days

Booth (1911)

1900 Parkland St., S.E.

U. S. Naval Hospital

WILLIAM

JOSEPH

WILLIAM

Commission

10-3-63

Illinois

U. S. Marine Corps

Officer

Seaman 1000

NAVY MINIST

(2) Mrs. Katherine Simon, Box 310, Michigan

310-20-000

1911-1912

Admission, office, with statement

1911-1912

May 23

May 2

XXXXXXXX

May 23

Brooklyn, N. Y., U. S. Naval Hospital, Boston, MA.

Admission Hospital

310-20-000

1911-1912

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

Items 18&21 Film 664 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6035 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05976

Item 2d, Film 664 6/20/60, cac.

| | | | | | |
|--|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)
c. LENGTH OF STAY IN 1b
6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
U. S. Naval Hospital | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville
d. STREET ADDRESS
Way 1402 Langley Drive
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
Charles Francis MONAGHAN | | | 4. DATE OF DEATH
May 27 19 60 | | |
| 5. SEX
Male | 6. COLOR OR RACE
Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-7-08 | 9. AGE (In years last birthday)
51 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Navy | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Alfred MONAGHAN | | |
| 14. MOTHER'S MAIDEN NAME
Mary Emma PYLE | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes WWII | | |
| 16. SOCIAL SECURITY NO.
243-44-2723 | | | 17. INFORMANT
Hospital Records | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 816 X Coronary insufficiency & arterial fibrillation
DUE TO (b) & heart block - Myocardial ischemia - Pulm. cong.
DUE TO (c) Rupture of urinary bladder
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
6 days | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 days |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
was driver of car which struck rear of other car | | |
| 20c. TIME OF INJURY
Month, Day, Year
2:10 xx May 21 1960 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
1/10 mile north Kenilworth Street-Balt. Wash. Expressway, Exchange Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type)
Frank J. BROSCHART, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | DATE SIGNED
5-27-60 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6-1-60 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | |
| | | | | 22d. LOCATION (City, town, or country) (State)
Arlington Virginia | |
| 23. FUNERAL DIRECTOR
R.A. Pumphrey | | | 24a. REC'D BY REGISTRAR
Arthur L. Hines | | |
| ADDRESS
Bethesda, Md. | | | DATE
JUN 1 '60 | | |

MEDICAL CERTIFICATION

2

15

2

WANT



Montgomery

Bethesda (Rural)

6 days

Iviesville

P.O.

Myland

U. S. Naval Hospital

1402 Lantley Drive

Charles

Frederic

MOMAGHAN

Way

ST 60

Male

Carrollton

10-7-06

10-7-06

SI

Warner

U. S. Navy

Pennsylvania

U.S.A.

Alfred MOMAGHAN

1414 Rome FIVE

Yes

ALL

2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340-1341-1342-1343-1344-1345-1346-1347-1348-1349-1350-1351-1352-1353-1354-1355-1356-1357-1358-1359-1360-1361-1362-1363-1364-1365-1366-1367-1368-1369-1370-1371-1372-1373-1374-1375-1376-1377-1378-1379-1380-1381-1382-1383-1384-1385-1386-1387-1388-1389-1390-1391-1392-1393-1394-1395-1396-1397-1398-1399-1400-1401-1402-1403-1404-1405-1406-1407-1408-1409-1410-1411-1412-1413-1414-1415-1416-1417-1418-1419-1420-1421-1422-1423-1424-1425-1426-1427-1428-1429-1430-1431-1432-1433-1434-1435-1436-1437-1438-1439-1440-1441-1442-1443-1444-1445-1446-1447-1448-1449-1450-1451-1452-1453-1454-1455-1456-1457-1458-1459-1460-1461-1462-1463-1464-1465-1466-1467-1468-1469-1470-1471-1472-1473-1474-1475-1476-1477-1478-1479-1480-1481-1482-1483-1484-1485-1486-1487-1488-1489-1490-1491-1492-1493-1494-1495-1496-1497-1498-1499-1500-1501-1502-1503-1504-1505-1506-1507-1508-1509-1510-1511-1512-1513-1514-1515-1516-1517-1518-1519-1520-1521-1522-1523-1524-1525-1526-1527-1528-1529-1530-1531-1532-1533-1534-1535-1536-1537-1538-1539-1540-1541-1542-1543-1544-1545-1546-1547-1548-1549-1550-1551-1552-1553-1554-1555-1556-1557-1558-1559-1560-1561-1562-1563-1564-1565-1566-1567-1568-1569-1570-1571-1572-1573-1574-1575-1576-1577-1578-1579-1580-1581-1582-1583-1584-1585-1586-1587-1588-1589-1590-1591-1592-1593-1594-1595-1596-1597-1598-1599-1600-1601-1602-1603-1604-1605-1606-1607-1608-1609-1610-1611-1612-1613-1614-1615-1616-1617-1618-1619-1620-1621-1622-1623-1624-1625-1626-1627-1628-1629-1630-1631-1632-1633-1634-1635-1636-1637-1638-1639-1640-1641-1642-1643-1644-1645-1646-1647-1648-1649-1650-1651-1652-1653-1654-1655-1656-1657-1658-1659-1660-1661-1662-1663-1664-1665-1666-1667-1668-1669-1670-1671-1672-1673-1674-1675-1676-1677-1678-1679-1680-1681-1682-1683-1684-1685-1686-1687-1688-1689-1690-1691-1692-1693-1694-1695-1696-1697-1698-1699-1700-1701-1702-1703-1704-1705-1706-1707-1708-1709-1710-1711-1712-1713-1714-1715-1716-1717-1718-1719-1720-1721-1722-1723-1724-1725-1726-1727-1728-1729-1730-1731-1732-1733-1734-1735-1736-1737-1738-1739-1740-1741-1742-1743-1744-1745-1746-1747-1748-1749-1750-1751-1752-1753-1754-1755-1756-1757-1758-1759-1760-1761-1762-1763-1764-1765-1766-1767-1768-1769-1770-1771-1772-1773-1774-1775-1776-1777-1778-1779-1780-1781-1782-1783-1784-1785-1786-1787-1788-1789-1790-1791-1792-1793-1794-1795-1796-1797-1798-1799-1800-1801-1802-1803-1804-1805-1806-1807-1808-1809-1810-1811-1812-1813-1814-1815-1816-1817-1818-1819-1820-1821-1822-1823-1824-1825-1826-1827-1828-1829-1830-1831-1832-1833-1834-1835-1836-1837-1838-1839-1840-1841-1842-1843-1844-1845-1846-1847-1848-1849-1850-1851-1852-1853-1854-1855-1856-1857-1858-1859-1860-1861-1862-1863-1864-1865-1866-1867-1868-1869-1870-1871-1872-1873-1874-1875-1876-1877-1878-1879-1880-1881-1882-1883-1884-1885-1886-1887-1888-1889-1890-1891-1892-1893-1894-1895-1896-1897-1898-1899-1900-1901-1902-1903-1904-1905-1906-1907-1908-1909-1910-1911-1912-1913-1914-1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-2459-2460-2461-2462-2463-2464-2465-2466-2467-2468-2469-2470-2471-2472-2473-2474-2475-2476-2477-2478-2479-2480-2481-2482-2483-2484-2485-2486-2487-2488-2489-2490-

1 after death. Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6036
CERTIFICATE OF DEATH

05977

| | | | |
|--|--------------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)
c. LENGTH OF STAY IN lb
7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Virginia
b. COUNTY
Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arlington
83X-3
d. STREET ADDRESS
4210 Lee Highway
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First
Kenneth
Middle
Donald
Last
MORGAN | | 4. DATE OF DEATH
Month
May
Day
26
Year
19 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-19-60 |
| 9. AGE (In years lost birthday) yrs.
7 | | 10. IF UNDER 1 YEAR
Months
7
Days
7
Hours
7
Min.
7 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
- - - - - | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Donald C. MORGAN | | 14. MOTHER'S MAIDEN NAME
Darlene J. YEAGER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
763.5 Hemorrhagic pneumonia and probable septicemia
DUE TO (a)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Prematurity, with 34 0 oz.
INTERVAL BETWEEN ONSET AND DEATH
8 hrs.
24 hrs. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) which occurred attended the deceased from May 19 10:15 1960 , to May 26 1960 , that (I) we last saw the deceased alive on May 26 1960 , and that death occurred at 10:15 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
G. B. Avery
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22b. DATE SIGNED
5-26-60 | | | |
| 22c. PHYSICIAN'S NAME (Type)
G. B. AVERY, LT, MC, USN
22d. ADDRESS
U. S. Naval Hospital, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Funeral Shipment
23b. DATE THEREOF
5/20/60
23c. NAME OF CEMETERY OR CREMATORY
Elmwood Cemetery
23d. LOCATION (City, town, or county) (State)
Lorraine Ohio | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
R. A. PUMPHREY
ADDRESS
Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR
JUN 1 '60
25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

215181XVI

CERTIFICATE OF DEATH

Reg. Dist. No.

5947

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>240 N. Washington St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Charles Raymond</u> First <u>MOTEN</u> Middle Last | | 4. DATE OF DEATH <u>5</u> Month <u>18</u> Day <u>1960</u> Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 7, 1896</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John D. Moten</u> | | 14. MOTHER'S MAIDEN NAME <u>Julia E. Nelson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.I</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>MOTHER</u> Address <u>240 N. Washington</u> | | 17. INFORMANT <u>Julia E. Nelson Moten</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma,</u>
<u>162.1</u> DUE TO <u>RT. Lung.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>59</u> , to <u>5-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>60</u> , and that death occurred at <u>12:50</u> P.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Clive E. Jackson, MD.</u> | | ADDRESS (Street, city or town, state) <u>202 Martin Ln, Rockville</u> DATE SIGNED <u>5-18-60</u> | |
| PHYSICIAN'S NAME (Type) <u>CLIVE E. JACKSON</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5/23/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National.</u> | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden</u> ADDRESS <u>Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAY 25 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Clive E. Jackson</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5913

05979

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>
c. LENGTH OF STAY IN 1b <u>4 days</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Clarksburg</u>
d. STREET ADDRESS <u>Route 1</u> | | | |
| 3. NAME OF DECEASED
First <u>Nora</u> Middle <u>Lee</u> Last <u>Mulligan</u>
(Type or print) | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>14</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u>
6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-1-02</u>
9. AGE (in years lost birthday) <u>57</u> yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Charles E. Eup</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Lola Jeffers</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | | | 17. INFORMANT <u>Hospital Records</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>
<u>331X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. }
(b) <u>Cerebral Vascular Accident</u> DUE TO
(c) <u>Hypertension</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Diabetes Mellitus and Enlarged Heart</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-9</u> 19 <u>60</u> , to <u>5-14</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> 19 <u>60</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Stuart L. Nelson</u> | | | | 22b. DATE SIGNED <u>5-14-60</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>STUART L. Nelson</u> | | | | 22d. ADDRESS <u>Washington Sanitarium Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/17/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Church Cem</u> | | | |
| 23d. LOCATION (City, town, or county) <u>Neelsville, Maryland</u> | | (State) | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u> | | | |
| 25a. REC'D BY REGISTRAR DATE <u>MAY 17 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6037

CERTIFICATE OF DEATH

Reg. Dist. No.

05980

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bathesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>47 Bethesda</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>7211 Fairfax Road</u> | | | | 1d. STREET ADDRESS
<u>7211 Fairfax Road</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mary</u> Middle <u>Arnold</u> Last <u>Munson</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>13</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 26, 1870</u> | |
| 9. AGE (In years lost birthday)
<u>89</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Govt.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Ohio</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>William Arnold</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Lydia Hunter</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
<u>Katherine M. Hunter</u> Address <u>7211 Fairfax Rd. Bethesda Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 wks.</u>
<u>years.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>October, 1959</u> to <u>May 13, 1960</u> , that I last saw the deceased alive on <u>May 12, 1960</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J.B. MacGregor</u> | | | | M.D. <u>Washington Clinic</u> DATE SIGNED <u>5/13/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>J. B. MacGregor</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5/16/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Oakwood</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Falls Church Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Pearson's Funeral Home</u> | | | | ADDRESS
<u>Falls Church Va.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 16 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kline</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5914
CERTIFICATE OF DEATH
05981

| | | | | | | |
|--|----------------------------------|--|--------------------------------------|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u>
c. LENGTH OF STAY IN 1b
<u>4 days</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Washington Sanitarium & Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
<u>Maryland</u>
b. COUNTY
<u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington</u>
d. STREET ADDRESS
<u>4107 Warner St.</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Frances</u> Middle <u>—</u> Last <u>Muscattello</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>16</u> Year <u>1960</u> | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8-15-1880</u> | 9. AGE (In years last birthday)
<u>79</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>own home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Joseph Scarfo</u> | | 14. MOTHER'S MAIDEN NAME
<u>Frances ?</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>NO</u> | | |
| 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>Hospital Records</u> | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic heart disease</u> DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Bleeding Gastric Ulcer</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>None</u> | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u>none</u> 19
p. m. <u>none</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/30/60</u> to <u>5/16, 1960</u> , that (I) (we) last saw the deceased alive on <u>5/15, 1960</u> , and that death occurred at <u>4:40</u> a.m., from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE
<u>John B. Umhan</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>5/16/60</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN B. UMHAN</u> | | 22d. ADDRESS
<u>8805 CONN. AVE CH. CH. MD.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>5/18/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>ROCK CREEK CEMETERY</u> | | 23d. LOCATION (City, town, or county) (State)
<u>WASHINGTON, D.C.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Raymond A. Zucka</u> | | ADDRESS
<u>SILVER SPRING, MD.</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 17 '60</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> |

1850

STATE OF NEW YORK

1850

IN SENATE,
January 1, 1850.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE,
IN ANSWER TO A RESOLUTION
PASSED BY THE SENATE,
MAY 1, 1849.
ALBANY:
PUBLISHED BY
J. B. KNEELAND, 1850.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5892

CERTIFICATE OF DEATH

05982

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Springs | | c. LENGTH OF STAY IN lb
2 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
10818 Wheeler Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Vincenzo Middle Naccarato Last Naccarato | | 4. DATE OF DEATH
Month May Day 29 Year 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 11, 1908 |
| 9. AGE (In years last birthday)
51 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Contractor | | 10b. KIND OF BUSINESS OR INDUSTRY
Sewer & Water Pipes | |
| 11. BIRTHPLACE (State or foreign country)
Italy | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Lougia Naccarato | | 14. MOTHER'S MAIDEN NAME
Caroline ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
Will | |
| 17. INFORMANT
Angela Naccarato | | Address
Wife As # 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
420.1 IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
2 weeks | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 1959 to May 29, 1960 , that I last saw the deceased alive on May 29, 1960 , and that death occurred at 12 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Boris Rabkin M.D. 1019 University Boulevard East May 29, 1960
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type) BORIS RABKIN, M.D. Silver Spring, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 1, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State)
Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | ADDRESS
Hyattsville, Md. | |
| 24a. REC'D BY REGISTRAR
JUN 3 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. House | |

TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15

| | | | | | | | | | |
|------------------------|--|--------------------------|--|--------------------------|--|-------------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | 1910 | | Maryland | |
| Cause of Death | | Immediate Cause | | Underlying Cause | | Manner of Death | | Place of Death | |
| Heart Disease | | Myocardial Infarction | | Coronary Atherosclerosis | | Natural | | Home | |
| Date of Death | | Time of Death | | Place of Death | | Physician's Signature | | Physician's Title | |
| 1950 | | 10:00 AM | | 1234 Main St | | John Doe, M.D. | | Physician | |
| Signature of Informant | | Relationship to Deceased | | Signature of Physician | | Signature of Medical Examiner | | Signature of Registrar | |
| John Doe | | Son | | John Doe, M.D. | | John Doe, M.D. | | John Doe, M.D. | |
| Address of Informant | | Address of Deceased | | Address of Physician | | Address of Medical Examiner | | Address of Registrar | |
| 1234 Main St | | 1234 Main St | | 1234 Main St | | 1234 Main St | | 1234 Main St | |
| City | | City | | City | | City | | City | |
| Baltimore | | Baltimore | | Baltimore | | Baltimore | | Baltimore | |
| State | | State | | State | | State | | State | |
| Maryland | | Maryland | | Maryland | | Maryland | | Maryland | |
| County | | County | | County | | County | | County | |
| Baltimore | | Baltimore | | Baltimore | | Baltimore | | Baltimore | |
| Zip Code | | Zip Code | | Zip Code | | Zip Code | | Zip Code | |
| 21201 | | 21201 | | 21201 | | 21201 | | 21201 | |

#1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05983

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 Silver Spring</u> | | d. STREET ADDRESS <u>515 Bonifant Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montg Co. Gen Hosp</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Homer Newton Nick</u> | | First Middle Last | | 4. DATE OF DEATH <u>May 20 1960</u> | | Month Day Year | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-13-1904</u> 56 yrs. | |
| 9. AGE (In years last birthday) <u>56</u> | | 10. IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u> | | 11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u> | | 11. BIRTHPLACE (State or foreign country) <u>Texas</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u> | | | | | | | |
| 13. FATHER'S NAME <u>Jim Nick</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Alice Newton</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <u>Edna Nick (wife)</u> | | | | Address <u>Ilm 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 2Df. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 22b. DATE THEREOF <u>MAY 24 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. CEM.</u> | |
| 22d. LOCATION (City, town, or country) <u>ARLINGTON, VIRGINIA</u> | | | | (State) | | | |
| 23. FUNERAL DIRECTOR <u>Martin W. Lyson Co.</u> ADDRESS <u>Wash. D.C. 1300-N.W.</u> | | | | 24a. REC'D BY REGISTRAR <u>MAY 23 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

MEDICAL CERTIFICATION

THE CIVIL
ENGINEER

6038

ARLINGTON NATIONAL CEMETERY, ARLINGTON, VIRGINIA

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6039
CERTIFICATE OF DEATH

05984
 Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
5 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
50 Bethesda | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
4414 Chestnut Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Amy Middle Lucille Last Nifong | | | | 4. DATE OF DEATH
Month May Day 11 Year 1960 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
February 16, 1915 | | 9. AGE (In years lost birthday)
45 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Audit & Claims Supervisor U.S. Government | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Crowder | | | | 14. MOTHER'S MAIDEN NAME
Mary Chesser | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Unascertainable | | INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Respiratory failure
DUE TO (b) Malignant Melanoma, Metastatic
DUE TO (c) 1960-9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
Diabetes mellitus | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 6 , 19 60 , to May 11 , 19 60 that I last saw the deceased alive on May 11 , 19 60 , and that death occurred at 4:30 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/11/60
ACTUAL SIGNATURE William O. Jones M.D. The Clinical Center
PHYSICIAN'S NAME (Type) William O. Jones, M.D. National Institutes of Health
Bethesda 14, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-14-60 | | 22c. NAME OF CEMETERY OR CREMATORY
Methodist Church Cem | | 22d. LOCATION (City, town, or county) (State)
St. Mary's County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | 24a. REC'D BY REGISTRAR
DATE MAY 13 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |



| | | | | | |
|------------------------|--|-----------------------------|--|----------------------|--|
| Name of Deceased | | Date of Birth | | Sex | |
| John Doe | | 1900-01-01 | | Male | |
| Place of Birth | | Date of Death | | Cause of Death | |
| New York, N.Y. | | 1950-01-01 | | Heart Disease | |
| Occupation | | Residence | | Burial Place | |
| Teacher | | 123 Main St, New York, N.Y. | | Cemetery | |
| Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| [Signature] | | [Signature] | | [Signature] | |
| Date of Certificate | | Place of Issuance | | Official Seal | |
| 1950-01-01 | | New York, N.Y. | | [Seal] | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5893 CERTIFICATE OF DEATH

05985

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>DC</u> b. COUNTY <u>Washington DC</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u> | | | | c. LENGTH OF STAY IN 1b <u>8 days</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> | | | | 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cedarcroft San & Hospital</u> | | | | d. STREET ADDRESS <u>5512 Second St. N.W.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Estelle May Nott</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>5</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-16-59</u> | |
| 9. AGE (In years lost birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR
Months <u>70</u> Days <u>5</u> Hours <u>19</u> Min. <u>60</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of last year (even if retired)) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | | |
| 13. FATHER'S NAME <u>William Henderson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Esther Jones</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Daughter - Mrs Evelyn Bell & Chart</u> | | Address <u>Same as Item #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u>& diabetic arteritis.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 26, 1960</u> to <u>May 3rd, 1960</u> that (I) (we) last saw the deceased alive on <u>May 3, 1960</u> and that death occurred at <u>1:14 P</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Aldo Vacca MD</u> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>5-5-60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Aldo Vacca</u> | | | | 22d. ADDRESS <u>1429 Univers. Blvd, W, Silver Spr. Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>5/9/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u> | | 23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. CO., MARYLAND</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey Inc.</u> | | | | ADDRESS <u>SILVER SPRING, MD.</u> | | 25a. REC'D BY REGISTRAR DATE <u>MAY 6 '60</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6040

CERTIFICATE OF DEATH

05986

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>121 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Elkton</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>The Clinical Center, Bethesda 14, Md.</u> | | | | d. STREET ADDRESS
<u>R. D. #2</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Adell</u> Middle <u>Marie</u> Last <u>Olah</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>19</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>January 10, 1916</u> | |
| 9. AGE (In years last birthday)
<u>44</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>John Jackowski</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Constance (Unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>164-16-4682</u> | | | |
| 17. INFORMANT
<u>The Medical Record</u> Address
<u>Unascertainable The Clinical Center, Bethesda 14, Maryland</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>204.3</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u>
DUE TO (c) <u>Acute Myelogenous Leukemia</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>5 minutes</u>
<u>10 hours</u>
<u>5 months</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>January 19, 1960</u> , to <u>May 19, 1960</u> , that I last saw the deceased alive on <u>May 19, 1960</u> , and that death occurred at <u>6:55 A.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>The Clinical Center</u> <u>5/19/60</u>
<u>National Institutes of Health</u>
<u>Bethesda 14, Maryland</u> | | | | | | | |
| ACTUAL SIGNATURE
<u>Charles E. Mengel</u> | | PHYSICIAN'S NAME (Type)
<u>Charles E. Mengel, M.D.</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 23, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Immaculate Conception, nr. Elkton, Md.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>PIPPIN FUNERAL HOME</u> | | | | ADDRESS
<u>Elkton, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>MAY 25 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Thomas</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

11-10-20

and day of

| | | | | | | | |
|----------------------------------|--|-----------------------------------|--|-----------------------------------|--|----------------------------------|--|
| <p>1. Name of deceased</p> | | <p>2. Sex</p> | | <p>3. Age</p> | | <p>4. Date of birth</p> | |
| <p>5. Place of birth</p> | | <p>6. Usual residence</p> | | <p>7. Cause of death</p> | | <p>8. Date of death</p> | |
| <p>9. Signature of physician</p> | | <p>10. Signature of registrar</p> | | <p>11. Signature of informant</p> | | <p>12. Date of registration</p> | |
| <p>13. Name of funeral home</p> | | <p>14. Name of undertaker</p> | | <p>15. Name of cemetery</p> | | <p>16. Name of lot</p> | |
| <p>17. Name of family</p> | | <p>18. Name of next of kin</p> | | <p>19. Name of executor</p> | | <p>20. Name of administrator</p> | |
| <p>21. Name of guardian</p> | | <p>22. Name of trustee</p> | | <p>23. Name of agent</p> | | <p>24. Name of attorney</p> | |
| <p>25. Name of witness</p> | | <p>26. Name of witness</p> | | <p>27. Name of witness</p> | | <p>28. Name of witness</p> | |
| <p>29. Name of witness</p> | | <p>30. Name of witness</p> | | <p>31. Name of witness</p> | | <p>32. Name of witness</p> | |
| <p>33. Name of witness</p> | | <p>34. Name of witness</p> | | <p>35. Name of witness</p> | | <p>36. Name of witness</p> | |
| <p>37. Name of witness</p> | | <p>38. Name of witness</p> | | <p>39. Name of witness</p> | | <p>40. Name of witness</p> | |
| <p>41. Name of witness</p> | | <p>42. Name of witness</p> | | <p>43. Name of witness</p> | | <p>44. Name of witness</p> | |
| <p>45. Name of witness</p> | | <p>46. Name of witness</p> | | <p>47. Name of witness</p> | | <p>48. Name of witness</p> | |
| <p>49. Name of witness</p> | | <p>50. Name of witness</p> | | <p>51. Name of witness</p> | | <p>52. Name of witness</p> | |
| <p>53. Name of witness</p> | | <p>54. Name of witness</p> | | <p>55. Name of witness</p> | | <p>56. Name of witness</p> | |
| <p>57. Name of witness</p> | | <p>58. Name of witness</p> | | <p>59. Name of witness</p> | | <p>60. Name of witness</p> | |
| <p>61. Name of witness</p> | | <p>62. Name of witness</p> | | <p>63. Name of witness</p> | | <p>64. Name of witness</p> | |
| <p>65. Name of witness</p> | | <p>66. Name of witness</p> | | <p>67. Name of witness</p> | | <p>68. Name of witness</p> | |
| <p>69. Name of witness</p> | | <p>70. Name of witness</p> | | <p>71. Name of witness</p> | | <p>72. Name of witness</p> | |
| <p>73. Name of witness</p> | | <p>74. Name of witness</p> | | <p>75. Name of witness</p> | | <p>76. Name of witness</p> | |
| <p>77. Name of witness</p> | | <p>78. Name of witness</p> | | <p>79. Name of witness</p> | | <p>80. Name of witness</p> | |
| <p>81. Name of witness</p> | | <p>82. Name of witness</p> | | <p>83. Name of witness</p> | | <p>84. Name of witness</p> | |
| <p>85. Name of witness</p> | | <p>86. Name of witness</p> | | <p>87. Name of witness</p> | | <p>88. Name of witness</p> | |
| <p>89. Name of witness</p> | | <p>90. Name of witness</p> | | <p>91. Name of witness</p> | | <p>92. Name of witness</p> | |
| <p>93. Name of witness</p> | | <p>94. Name of witness</p> | | <p>95. Name of witness</p> | | <p>96. Name of witness</p> | |
| <p>97. Name of witness</p> | | <p>98. Name of witness</p> | | <p>99. Name of witness</p> | | <p>100. Name of witness</p> | |

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|---|--|--|--|--|--|--|--|---|--|---------------------------------------|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | | | b. COUNTY
Baltimore | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b
DOA | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Long Green | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
U. S. Naval Hospital | | | | d. STREET ADDRESS
Drop Anchor | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Howard Thomas ORVILLE | | | | 4. DATE OF DEATH
Month Day Year
May 24 1960 | | | | | | | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-16-01 | | 9. AGE (In years last birthday)
58 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Naval Officer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Navy | | | | 11. BIRTHPLACE (State or foreign country)
Wyoming | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
William ORVILLE | | | | | | 14. MOTHER'S MAIDEN NAME
Lucy WYANT | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
Yes 1925-1950 | | | | 16. SOCIAL SECURITY NO.
216-30-0958 | | 17. INFORMANT
Hospital Records | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
} DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. | | | | | | | | | | | | DATE SIGNED
5-25-60 | | | | | |
| EXAMINER'S NAME (Type) Frank J. BROSCHART | | | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | | | | | | 22b. DATE THEREOF
5-27-60 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or country) (State)
Arlington Virginia | |
| 23. FUNERAL DIRECTOR
Brooks Funeral Service, 622 York Rd. Towson 4, | | | | | | | | | | | | 24a. REC'D BY REGISTRAR
Md. MAY 27 '60 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. House</i> | | | |

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CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN lb
14 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Germantown | | d. STREET ADDRESS
Middlebrook Trailer Court | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Beggy Middle A. Last Owens | | | | 4. DATE OF DEATH
Month May Day 14 Year 1960 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
2/8/36 | 9. AGE (In years last birthday)
24 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Speedwell, Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
George Blain Patton | | | | 14. MOTHER'S MAIDEN NAME
Laura L. Weeks | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | INFORMANT Address
Mr. H.R. Owens Middlebrook Trailer Ct. Germantown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Exsanguination
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Invasion of right iliac vein by metastatic tumor
DUE TO (c) Squamous cell carcinoma of uterine cervix
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
16 hr.
unknown
approx 18 mo. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 13, 1960 to May 14, 1960 that I last saw the deceased alive on May 14, 1960 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 5205 Dorset Ave. Chevy Chase 15 Md.
DATE SIGNED 5-14-60
ACTUAL SIGNATURE J. Roscoe Creever M.D.
PHYSICIAN'S NAME (Type) J. Roscoe Creever M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 5-16-60 | | Marion Cemetery | | Marion ve | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James B. Parker | | | | 24a. REC'D BY REGISTRAR
DATE MAY 16 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED IN THE
OFFICE OF THE
SHERIFF

STATE OF
NEW YORK

IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONER

OF THE

LAND OFFICE

FOR THE YEAR

1899

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05989

| | | | | | | | | | | | | |
|---|--|---------------------------|--|---|--|--|--|---|--|--|--|----------------|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | | | b. COUNTY
Montgomery | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Olney | | | | c. LENGTH OF STAY IN 1b
3 days | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
X Monrovia | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Montgomery Co. General Hosp. | | | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Martha Elizabeth Parsley | | | | 4. DATE OF DEATH
Month Day Year
May 18, 19 60 | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9.13.1878 | | 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homework | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Thomas Parsley | | | | 14. MOTHER'S MAIDEN NAME
Mary Ward | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Hospital Records | | Address
Olney, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarct | | | | | | | | | | | | |
| 903.0 DUE TO sudden | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary thrombosis | | | | | | | | | | | | |
| DUE TO Fractures of left humerus and left knee. 2½ days | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Fell on floor at home | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour XX
9:30 p.m. 5.15. 19 60 | | | | 20d. INJURY OCCURRED
While Not While
at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town)
Monrovia | | (County)
Montg. | | (State)
Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | | | M.D.
Assistant Medical Examiner <input type="checkbox"/> | | | | 5.18.60 DATE SIGNED | | | | |
| EXAMINER'S NAME (Type)
Frank J. Broschart | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Address (Street, city, town, or county) | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
May 21 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Laytonsville | | 22d. LOCATION (City, town, or country)
Laytonsville | | (State)
Md. | | |
| 23. FUNERAL DIRECTOR
Francis H. Barber | | | | ADDRESS
Laytonsville, Md. | | | | 24a. REC'D BY REGISTRAR
MAY 23 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hume | | |

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | d. STREET ADDRESS <u>3802 Brandywine St.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>George R. Payne</u> | | 4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/5/1884</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Worker</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Andrew L. Payne</u> | | 14. MOTHER'S MAIDEN NAME <u>Wendel</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| INFORMANT <u>C. Wendel Shoemaker</u> | | Address <u>3747 N. Granada St. Arl. Va.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal Failure</u>
DUE TO (b) <u>Nephritis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Hypertensive neuropathy - Poststroke</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
<u>2 weeks</u>
<u>unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not-white at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1950</u> , to <u>May 27</u> , 1960 that I last saw the deceased alive on <u>May 26</u> , 1960, and that death occurred at <u>8:10 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Stewart Clapp</u> | | ADDRESS (Street, city or town, state) <u>3921 Ingomar St NW Wash DC</u> | |
| PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> | | DATE SIGNED <u>5/27/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5/31/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Maryland</u> | |
| 24a. REC'D BY REGISTRAR <u>JUN 1 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911 12/10/11

Dr. A. J. [illegible] [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05991

5913

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|-------------------------------|--|--|--|---------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md</i> b. COUNTY <i>Pr. Geo.</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | | | c. LENGTH OF STAY IN lb <i>87 days</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Helen First Ormsbee Pedersen Last</i> | | | | 4. DATE OF DEATH <i>5-16-1960</i> Month Day Year | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>12-29-89</i> yrs. | |
| 9. AGE (In years last birthday) <i>70</i> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <i>N. Y.</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | | |
| 13. FATHER'S NAME <i>Robert McCade</i> | | | | 14. MOTHER'S MAIDEN NAME <i>unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <i>Washington Sanitarium & Hospital Rec.</i> Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>433-1 - cardiac - was cerebrovascular failure</i>
DUE TO (b) <i>- cerebro vascular accident</i>
DUE TO (c) <i>arteriosclerotic fibulation</i>
INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>- congestive heart failure</i> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>9-19-1960</i> to <i>5-16-1960</i> that (I) (we) last saw the deceased alive on <i>5-14-1960</i> and that death occurred at <i>10:45 AM</i> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Veronica Trost</i> M.D. | | | | 22b. DATE SIGNED <i>5-16-60</i> | | | |
| 22c. PHYSICIAN'S NAME (Type) <i>VERONICA TROST</i> | | | | 22d. ADDRESS <i>10236 NW Ave. SS. Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 23b. DATE THEREOF <i>May 19, 1960</i> | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>George Washington</i> | | | | 23d. LOCATION (City, town, or county) (State) <i>Hyattsville, Md.</i> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i> | | | | 25a. REC'D BY REGISTRAR <i>MAY 19 '60</i> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Smith</i> | | | |

TO HOSTEL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

68

6045

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u>
c. LENGTH OF STAY IN TB
<u>8 days</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
<u>Maryland</u>
b. COUNTY
<u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>41 Silver Spring</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>The Clinical Center, Bethesda 14, Md.</u> | | d. STREET ADDRESS
<u>2920 New Castle Avenue</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>Shirley May Porter</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>31</u> Year <u>19 60</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 29, 1913</u> |
| 9. AGE (In years last birthday) yrs.
<u>46</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>School Teacher</u> | 11. BIRTHPLACE (State or foreign country)
<u>Illinois</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>School Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Teaching</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Herman Walker</u> | | 14. MOTHER'S MAIDEN NAME
<u>Maude Dixon</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>214-12-7193</u> | |
| 17. INFORMANT
<u>The Medical Record</u> | | Address
<u>The Clinical Center, Bethesda 14, Maryland</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u>
DUE TO <u>Carcinoma, Left Breast with Metastases to</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Liver, Lungs and Spine.</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 days</u>
<u>4 Years</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____
19 _____ | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>May 23</u> , 19 <u>60</u> , to <u>May 31</u> , 19 <u>60</u> , that I last saw the deceased olive on <u>May 31</u> , 19 <u>60</u> , and that death occurred at <u>10:55p</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Saul Genuth</u> M.D. | | ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6-1-60</u> | |
| PHYSICIAN'S NAME (Type) <u>SAUL GENUTH, M.D.</u> | | <u>The Clinical Center</u>
<u>National Institutes of Health</u>
<u>Bethesda 14, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | 22b. DATE THEREOF
<u>6/3/60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National Cem. Ft. Myer, Va.</u> | 22d. LOCATION (City, town, or county) _____ (State) _____ |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>The S.H. Hines Co. Washington 9, D.C.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JUN 3 '60</u> | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------------------|--|---------------------------------|--|----------------------------------|--|-----------------------------------|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | | <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | |
| <p>5. PLACE OF BIRTH</p> | | <p>6. OCCUPATION</p> | | <p>7. CAUSE OF DEATH</p> | | <p>8. PLACE OF DEATH</p> | |
| <p>9. DATE OF DEATH</p> | | <p>10. TIME OF DEATH</p> | | <p>11. SIGNATURE OF DECEASED</p> | | <p>12. SIGNATURE OF WITNESSES</p> | |
| <p>13. SIGNATURE OF PHYSICIAN</p> | | <p>14. SIGNATURE OF CORONER</p> | | <p>15. SIGNATURE OF JUDGE</p> | | <p>16. SIGNATURE OF CLERK</p> | |

41

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5894 CERTIFICATE OF DEATH 05993

| | | | | | |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | c. LENGTH OF STAY IN 1b
6 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
25 SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
812 BURLINGTON DRIVE | | | d. STREET ADDRESS
812 BURLINGTON DRIVE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
CHARLES First ALFRED Middle PRATT Last | | | 4. DATE OF DEATH
MAY Month 6 Day 19 60 Year | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/19/11 | | 9. AGE (In years lost birthday)
49 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Air Conditioning Mechanic | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. |
| 13. FATHER'S NAME
Charles T. Pratt | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 14. MOTHER'S MAIDEN NAME
Mary Louise Turner | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | |
| 16. SOCIAL SECURITY NO.
579-09-0980 | | | 17. INFORMANT
Mrs. Florence V. Pratt, 812 Burlington Dr. Address Silver Spring, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 002X Sal tuberculosis DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 6, 1960 to May 6, 1960 , that (I) (we) last saw the deceased alive on May 6, 1960 , and that death occurred at reported M, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
E. R. Fenton | | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type)
E. R. FENTON | | | 22d. ADDRESS
1801 Eye St., N.W., WASHINGTON, D.C. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5/10/60 | | 23c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEMETERY | |
| 23d. LOCATION (City, town, or county)
WASHINGTON, D.C. | | (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Raymond B. Giska | | | 25a. REC'D BY REGISTRAR
DATE MAY 11 '60 | | |
| 25b. REGISTRAR'S SIGNATURE
Charles S. Kline | | | | | |

25

CERTIFICATE OF DEATH

Reg. Dist. No.

6046

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda
c. LENGTH OF STAY IN 1b
9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda
d. STREET ADDRESS
8515 Woodhaven Blvd.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Sarah Rancourt | | 4. DATE OF DEATH
Month Day Year
May 10 1960 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/16/80 |
| 9. AGE (In years last birthday)
79 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.
4 24 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
---- | |
| 11. BIRTHPLACE (State or foreign country)
St. Come, Canada | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
George Poul in | | 14. MOTHER'S MAIDEN NAME
Poulin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
None | |
| INFORMANT
Mrs. Algie Wells | | Address
8515 Woodhaven Blvd. Beth. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
428.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease
DUE TO (c) Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH
4 DAYS
2 YRS
20 YRS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 24, 1960 , to May 10, 1960 , that I last saw the deceased alive on May 10, 1960 , and that death occurred at 6 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Leo I. Donovan M.D. | | ADDRESS (Street, city or town, state)
8218 Wisconsin Ave Bethesda MD | |
| PHYSICIAN'S NAME (Type)
LEO I DONOVAN M.D. | | DATE SIGNED
5/10/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Bur-Transit | 22b. DATE THEREOF
5/11/60 | 22c. NAME OF CEMETERY OR CREMATORY
Pine Grove Cemetery | 22d. LOCATION (City, town, or county) (State)
Waterville, Maine |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | ADDRESS
Bethesda, Maryland | |
| 24a. REC'D BY REGISTRAR
MAY 12 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. K... | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05995

5895

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | | c. LENGTH OF STAY IN 1b 11 Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8602 11th Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MARY JANE RAYNOR | | | | 4. DATE OF DEATH MAY 8 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Sept. 15, 1880 | |
| 9. AGE (In years last birthday) 79 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John T. Disney | | 14. MOTHER'S MAIDEN NAME Catherine Verr | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Lillian Higdon 8602 11th Ave., S.S.Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-Vascular Accident (stroke)
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION - Generalized Arteriosclerosis
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days

years. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 21. I certify that (I) (this hospital) attended the deceased from June 1955 to May 8 1960 , that (I) (we) last saw the deceased alive on MAY 7 1960 , and that death occurred at 5 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Ernest A. Sarao MD | | | | 22b. DATE MAY 8, 1960 | | 22c. PHYSICIAN'S NAME (Type) ERNEST A. SARAO, M.D. | |
| 22d. ADDRESS 7006 New Hampshire Ave., Takoma Park, Md. | | | | 22e. REC'D BY REGISTRAR MAY 11 '60 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF May 10, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery | |
| 23d. LOCATION (City, town, or county) Hyattsville, Maryland. | | | | 23e. REGISTRAR'S SIGNATURE Arthur L. Howard | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., | | | | 24b. ADDRESS Riverdale, Maryland. | | | |

20

6885

Montgomery County

Silver Spring

8002 1st Avenue

MARY

JANE

KAY

MAY

Female White

Age 30

Unmarried, D. A.

John F. Bryant

Defendant's Name

To: Mrs.

John

12111 41st St. N.E., Wash., D.C.

Child's Name: A. J. (John)

Hyper-Estrogen Syndrome (Hypothalamic)

1/2 1 1/2

George W. Bryant

Witness: John F. Bryant

Notary: John F. Bryant, Notary Public, Montgomery County, Maryland

Witness: John F. Bryant

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5896

CERTIFICATE OF DEATH

05996

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>24 Silver Springs Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>8406 Houston Street</u> | | d. STREET ADDRESS
<u>8406 Houston Street</u> | |
| 3. NAME OF DECEASED (Type or print) <u>NORMA L REDDY</u> | | 4. DATE OF DEATH <u>28 May 1960</u> | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan 9, 1915</u> |
| 9. AGE (In years last birthday)
<u>45</u> yrs. | | IF UNDER 1 YEAR
Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u> | IF UNDER 24 HRS.
Hours <u>00</u> Min. <u>00</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Auditor accounting</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U S Government</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Philadelphia Penna</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U S A</u> | |
| 13. FATHER'S NAME
<u>John Lynham Sr</u> | | 14. MOTHER'S MAIDEN NAME
<u>Norma Halstead</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>no</u> | |
| 17. INFORMANT
<u>Stephen J Reddy</u> | | Address
<u>Silver Springs, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
DUE TO (b) <u>Recurrent Carcinoma of Colon</u>
DUE TO (c) <u>Carcinoma of Colon.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u>
<u>3 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug 1, 1959</u> to <u>28 May, 1960</u> , that I last saw the deceased alive on <u>28 May, 1960</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thomas P Fogarty</u> M.D. | | ADDRESS (Street, city or town, state) <u>1011 UNIVERSITY BLVD E 18th St</u> DATE SIGNED <u>18 May 60</u> | |
| PHYSICIAN'S NAME (Type) <u>THOMAS P FOGARTY MD</u> | | <u>HYATTSVILLE P.G. Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>6/1/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Ft Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Colmar Manor, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>F. Gasch's Sons</u> | | ADDRESS
<u>Hyattsville, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>JUN 2 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kline</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

24

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6047

CERTIFICATE OF DEATH

05997

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
<u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u>
c. LENGTH OF STAY IN 1b
<u>68 days</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>The Clinical Center, Bethesda 14, Md.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
<u>Tennessee</u>
b. COUNTY
<u>Knoxville</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>79X-3</u>
d. STREET ADDRESS
<u>3714 Hampton Avenue</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>Earl Harrison Reed</u> | | | 4. DATE OF DEATH
Month Day Year
<u>May 19 1960</u> | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
<u>November 15, 1913</u> | | 9. AGE (In years last birthday)
<u>46</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Unascertainable</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Tennessee</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 13. FATHER'S NAME
<u>Marcus Lafayette Reed</u> | | | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Rosa May Talley</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | | |
| 16. SOCIAL SECURITY NO.
<u>413-05-1144</u> | | 17. INFORMANT
<u>The Medical Record</u> Address
<u>The Clinical Center, Bethesda 14, Maryland</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>200.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant lymphoma with widespread involvement</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cutaneous lymphangitis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 1/2 years</u> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>1960</u> | | | |
| 20f. (City or town)
<u>1960</u> | | 20g. (County)
<u>1960</u> | | 20h. (State)
<u>1960</u> | | | |
| 21. I certify that I attended the deceased from <u>March 12</u> , 19 <u>60</u> , to <u>May 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>60</u> , and that death occurred at <u>1:30 A</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>5/19/60</u>
NATIONAL INSTITUTES OF HEALTH
<u>Bethesda 14, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal-Burial</u> | | 22b. DATE THEREOF
<u>5/19/1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Oak Hill Cemetery</u> | | | |
| 22d. LOCATION (City, town, or county)
<u>Frederickburg, Virginia</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Everly-Wheatley Funeral Home, 1500 W. Braddock Rd. Alexandria, Va.</u> | | | | | |
| 24a. REC'D BY REGISTRAR
DATE <u>MAY 23 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hradek</u> | | | | | |

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

1

VS A15 (4)
15M 10/57

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)
c. LENGTH OF STAY IN 1b 22 days | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia ✓
b. COUNTY ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3
d. STREET ADDRESS 3063 30th Street, S. E. - Apt. 4
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Yetta Middle Gordon Last RELACH | | | | 4. DATE OF DEATH
Month May Day 18 Year 1960 | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-25-09 | | 9. AGE (In years lost birthday) 50 yrs. | | 10. IF UNDER 1 YEAR
Months 5 Days 18 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Department Store | | 11. BIRTHPLACE (State or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Solomon GORDON | | | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
578-07-1903 | | 17. INFORMANT Address
(S) Richard S. Relach, same as #2 above | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis
162.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma, left lung +
DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (the physician) attended the deceased from April 26, 1960, to May 18, 1960, that (I) (we) last saw the deceased alive on May 18, 1960, and that death occurred at 7P M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
F. S. Caldwell | | | | 22b. DATE SIGNED
5-19-60 | | | | 22c. PHYSICIAN'S NAME (Type)
F. S. CALDWELL, LT, MC, USN | | | |
| 22d. ADDRESS
U. S. Naval Hospital, Bethesda, Md. | | | | 22e. M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
5-23-60 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City, town, or county) (State)
Arlington Virginia | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Danzansky | | | | ADDRESS
Funeral Home, 3501 14th St., NW, WashDC | | | | 25a. REC'D BY REGISTRAR
MAY 20 '60 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

(M)

(I)

2

MEDICAL CERTIFICATION

6042

CERTIFICATE OF DEATH

6042

(M)

Residence

Bellevue (River)

62 days

Washington DC

Place of birth

U. S. Naval Hospital

3-23 John Street, B. E. - April 4

Yester

Given

REACH

May

10

60

Female

Caution

X

12-25-00

20

Older

Department Store

Poland

U.S.A.

Bellevue GORDON

Unknown

No

716-07-1903

(S) Richard S. Raines, same as above

INTERVIEW TO

60

17

April 22

May 12

60

60

7-10-00

X

F. E. CALDWELL, 12, NO. 100

U. S. Naval Hospital, Bethesda, Md.

Bellevue

Arlington National

Washington

Virginia

DAVIDSONSKI, Samuel, 2501 14th St., NW, WASHINGTON

CERTIFICATE OF DEATH

Reg. Dist. No.

5916

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. LENGTH OF STAY IN lb
<u>11 Months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>7100 Sycamore Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Lena M. Richardson</u> | | 4. DATE OF DEATH
<u>May 9 1960</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Mar 10 1874</u> | |
| 9. AGE (In years last birthday)
<u>86 yrs</u> | | 10. UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Sec</u> | | 11b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Gov</u> | |
| 11c. BIRTHPLACE (State or foreign country)
<u>Wash. D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Samuel S. Richardson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Tennie Wortham</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | |
| 17. INFORMANT
<u>Roy G. Richardson--1731 N.H. Ave., N.W.</u> | | Address <u>Wash. D.C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>331X Hypertensive Pneumonia</u>
DUE TO (b) <u>Chronic Tuberculosis with Decomp</u>
DUE TO (c) <u>Cerebral Hem. at Hemiplegia</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>3 days</u>
<u>9 wks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>7/2/56</u> , 19 <u>56</u> , to <u>5/9/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5/9/60</u> , 19 <u>60</u> , and that death occurred at <u>5:15 P</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Howard T. Morse</u> | | DATE SIGNED
<u>5/9/60</u> | |
| PHYSICIAN'S NAME (Type)
<u>Howard T. Morse</u> | | ADDRESS (Street, city or town, state)
<u>2030 Carroll Ave - Takoma Park Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>5/12/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Glenwood Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. S. H. Henner Co.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAY 12 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hearn</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6049

CERTIFICATE OF DEATH

Reg. Dist. No.

66000

| | | | |
|---|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>13 hrs.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Alvin</i> Middle <i>H</i> Last <i>Rick</i> | | 4. DATE OF DEATH Month <i>May</i> Day <i>17</i> Year <i>1960</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 30 1884</i> |
| 9. AGE (In years lost birthday) <i>76</i> yrs. | | 10. IF UNDER 1 YEAR Months <i>7</i> Days <i>10</i> Hours <i>10</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrical Engineer - Navy</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Jarius Rick</i> | | 14. MOTHER'S MAIDEN NAME <i>Annette Marburger</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>Ms. James B. Grim</i> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>465X Congestive heart failure</i>
DUE TO (b) <i>Pulmonary Embolism</i>
DUE TO (c) <i>5 mos.</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>5 mos.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Tuberculosis</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Oct 5-17</i> , 1959, to <i>5-17</i> , 1960 that I last saw the deceased alive on <i>5-17</i> , 1960, and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>W. G. Hall</i> | | ADDRESS (Street, city or town, state) <i>615 W. Montgomery Ave. Rockville, Md.</i> DATE SIGNED <i>5/17/60</i> | |
| PHYSICIAN'S NAME (Type) <i>W. G. Hall</i> | | 615 W. Montgomery Ave. Rockville, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-Transit</i> | | 22b. DATE THEREOF <i>5/19/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Alsace</i> | | 22d. LOCATION (City, town, or county) (State) <i>Hyde Park, Pennsylvania</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler</i> ADDRESS <i>1331 E. Montgomery Ave Rockville, Md</i> | | 24a. REC'D BY REGISTRAR DATE <i>MAY 20 '60</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5917

6001

| | | | | | | | |
|---|---------------------------|--|----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | |
| c. LENGTH OF STAY IN 1b <u>20 days</u> | | | | d. STREET ADDRESS <u>7222 Flower Ave</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen + Hosp.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Moore</u> Last <u>Robertson</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1960</u> | | | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-23-77</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. | IF UNDER 1 YEAR
Months <u>5</u> Days <u>10</u> Hours <u>16</u> Min. <u>54</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>George Halsey</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Alvira Freeman</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u> </u> | | | | 17. INFORMANT Address <u>Hospital Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Dehiscence Anastomotic site, colon with local</u>
<u>153.8</u> DUE TO <u>Peritonitis and abscess formation</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post-operative Colon Resection for Adenocarcinoma</u>
DUE TO <u>with Paralytic Ileus</u>
(c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month <u>4</u> Day <u>20</u> Year <u>1960</u>
Hour a. m. <u> </u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | | 21. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> <u>1960</u> to <u>5/10</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>5/10</u> <u>1960</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dean H. Harding</u> | | | | 22b. DATE SIGNED <u>5/10/60</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Dean H. Harding</u> | |
| 22d. ADDRESS <u>113 Carroll St NW, Wash DC</u> | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>11 May '60</u> | | | |
| 23b. DATE THEREOF <u>11 May '60</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u> | | 23d. LOCATION (City, town, or county) <u>Wash.</u> (State) <u>D.C.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home 300-4th St. NE</u> | | | | 25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 12 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u> </u> | |

MEDICAL CERTIFICATION

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

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54

7

6050

CERTIFICATE OF DEATH

6002

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda
c. LENGTH OF STAY IN 1b
11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Michigan
b. COUNTY
59X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Austin
d. STREET ADDRESS
754 Radar Squadron
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First
Daniel
Middle
Dean
Last
Rodd | | | 4. DATE OF DEATH
Month
May
Day
5
Year
19 60 | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 16, 1953 | | 9. AGE (In years lost birthday) yrs.
7 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Mississippi | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Kenneth Rodd | | | | |
| 14. MOTHER'S MAIDEN NAME
Irmo Talbert | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | | | |
| 16. SOCIAL SECURITY NO.
None | | | INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO
754-0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Respiratory failure
DUE TO
(c) Tetralogy of Fallot | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Life | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from April 24, 1960 to May 5, 1960 that I last saw the deceased alive on May 5, 1960 and that death occurred at 10:40 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland
DATE SIGNED 5/6/60 | | | | | | | |
| ACTUAL SIGNATURE
<i>Lazar Greenfield, M.D.</i> | | PHYSICIAN'S NAME (Type)
Lazar Greenfield, M. D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | 5/6/1960 | | Marion Cemetery | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Lazar Greenfield</i> | | ADDRESS
4557 | | 24a. REC'D BY REGISTRAR
DATE MAY 9 '60 | | | |
| 24b. REGISTRAR'S SIGNATURE
<i>Arthur L. Kraus</i> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6051

CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|-------------------------------|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D.C.
b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 27 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Pearl Middle C Last Rowe | | | | 4. DATE OF DEATH
Month May Day 8 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 7, 1890 | | 9. AGE (In years last birthday) 70 yrs. | IF UNDER 1 YEAR
Months 7 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Dakota | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Hatch | | | | 14. MOTHER'S MAIDEN NAME Lydia Johnson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 579-44-8832 | | INFORMANT Husband | | Address As above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443x Rt Cerebellar Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease
(c) many years | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 55 , to May 8 , 19 60 , that I last saw the deceased alive on May 7, 1960 , and that death occurred at 6 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Michael M. Healy | | ADDRESS (Street, city or town, state) Washington Clinic Washington D.C.
DATE SIGNED 5/8/60 | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/10/60 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 22d. LOCATION (City, town, or county) (State) Annandale Rd MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James E. Beltr | | ADDRESS 5103 Wisconsin Ave NW | | 24a. RECEIVED BY REGISTRAR MAY 12 1960 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Harris | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

110

1337-1342

6052

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Pr Georges Co | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt Rainier, 1648.2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban Hospital. | | d. STREET ADDRESS
2901 Allison St. | |
| 3. NAME OF DECEASED (Type or print)
First William E Middle Scull Last | | 4. DATE OF DEATH
Month 11 Day 17 Year 1960 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov 2 1892 |
| 9. AGE (In years last birthday)
67 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
General Accounting | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | |
| 11. BIRTHPLACE (State or foreign country)
Fla. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William E Scull | | 14. MOTHER'S MAIDEN NAME
Eleanor Kennedy, | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
W.W.1 | |
| 17. INFORMANT
Mrs Marjorie G Scull | | Address
WIFE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
203x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
3 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from FEB 26 , 19 43 to MAY 14 , 19 60 , that I last saw the deceased alive on MAY 14 , 19 60 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
P. F. Tabb, M.D. | | ADDRESS (Street, city or town, state)
13000 9A. AVE. SILVER SPRING, MD | |
| PHYSICIAN'S NAME (Type)
S. L. TABB, M.D. | | DATE SIGNED
5/14/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
5/18/60 | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Natl. Cem | 22d. LOCATION (City, town, or county) (State)
Arl Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. K. Huntman & Son | | 24. REGISTERED BY REGISTRAR
N.W. | |
| ADDRESS
5732 GEORGIA AVE. | | DATE
MAY 17 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

1923

St. Paul, Minn.

MA

January 10, 1923

Attest:

Witness:

Witness:

Attest:

Witness:

Attest:

Witness:

Attest:

Witness:

Witness:

Attest:

Witness:

Wife

Attest:

Witness:

6053

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|---|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
8 Hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
12 Kensington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban Hospital | | | d. STREET ADDRESS
5104 White Flint Dr. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Clifford Middle Warren Last Shanbarker | | | 4. DATE OF DEATH
Month May Day 18 Year 1960 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/21/94 | 9. AGE (In years last birthday)
65 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Telephone Mgr. | | 11. BIRTHPLACE (State or foreign country)
S. Dakota | |
| 13. FATHER'S NAME
Edgar Shanbarker | | | 14. MOTHER'S MAIDEN NAME
Hattie Hart | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) Yes | | | 16. SOCIAL SECURITY NO.
XX WW 1 390-09-170 | | |
| INFORMANT
Richard W. Shanbarker-son-same 2d | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 ANEURYSM, ABDOMINAL AORTA 2 HEMORRHAGE
DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost.
(b) THROMBOSIS, CORONARY
DUE TO
(c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 HOURS
5 HOURS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)
(County)
(State) | | |
| 21. I certify that I attended the deceased from 5-17 , 19 60 , to 5-18 , 19 60 , that I last saw the deceased alive on 5-18-60 , 19____, and that death occurred at 2:35 AM , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
Philip R. James | | ADDRESS (Street, city or town, state)
Washington Clinic, D.C.
DATE SIGNED
5/18/60 | | | |
| PHYSICIAN'S NAME (Type)
Philip R. James | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Bur-Transit | | 22b. DATE THEREOF
5/21/60 | | 22c. NAME OF CEMETERY OR CREMATORY
East Lawn Cemetery | |
| 22d. LOCATION (City, town, or county)
Beloit, Wisconsin | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | ADDRESS
Bethesda, Maryland | | 24a. REC'D BY REGISTRAR
DATE MAY 23 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hume | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

CERTIFICATE OF DEATH

Reg. Dist. No.

6054

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DERWOOD, MARYLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DERWOOD, MARYLAND | |
| c. LENGTH OF STAY IN 1b 5 YEARS | | d. STREET ADDRESS ROUTE 1, Box 241 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRIVATE RESIDENCE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First OLA Middle SHIKLE Last SHIKLE | | 4. DATE OF DEATH
Month MAY Day 19 Year 1960 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV. 22, 1868 |
| 9. AGE (In years lost birthday) 91 yrs. | | IF UNDER 1 YEAR
Months 9 Days 1 Hours 1 Min. | IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 11. BIRTHPLACE (State or foreign country) TENNESSEE |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOHN ROBERT KIRBY | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT SON Address DERWOOD, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO
(c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH 7 WEEKS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO. | |
| 20c. TIME OF INJURY
Month 19 Day 19 Year 1960
Hour 11 a. m. 15 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X | 20f. (City or town) X (County) (State) |
| 21. I certify that I attended the deceased from AUGUST 1, 1958 to MAY 19, 1960 , that I last saw the deceased alive on MAY 19, 1960 , and that death occurred at 10:15 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Belden R. Reap | | ADDRESS (Street, city or town, state) Wheaton, Md. DATE SIGNED 5/19/60 | |
| PHYSICIAN'S NAME (Type) BELDEN R. REAP, M.D. | | 11502 GRANDVIEW AVE. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| TRA'S. & BURIAL | 5/21/60 | SUDBURY CEMETERY | FRIENDSHIP, TENNESSEE |
| 23. FUNERAL DIRECTOR'S SIGNATURE
WERNER E. BOMBARDY, INC.
Raymond A. Jick | | ADDRESS SILVER SPRING, MD. | 24a. REC'D BY REGISTRAR
DATE MAY 23 '60 |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Howard | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

5941

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10717 Shaftbury Street., | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Kensington
d. STREET ADDRESS 10717 Shaftbury Street.,
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Simpson, Isabelle
Last Middle First Isabelle | | 4. DATE OF DEATH
Month May Day 28 Year 1960 | |
| 5. SEX F | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 15, 1876 |
| 9. AGE (In years, last birthday) 84 | | 10. IF UNDER 1 YEAR
Months 13 Days 10 Hours 10 Min. 10 | 11. IF UNDER 24 HRS.
Hours 10 Min. 10 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Rinalda Simpson | | 14. MOTHER'S MAIDEN NAME Rachel Snowden | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. INFORMANT Virgie Walker 10717 Shaftbury St., Kensington, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c) ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 1960 to present , that I last saw the deceased alive on 5/28/60 , and that death occurred at 10571 Summit Ave , from the causes and on the date stated above.
ACTUAL SIGNATURE George Shurpe M.D. 10571 Summit Ave 5/28/60
PHYSICIAN'S NAME (Type) George Shurpe Kensington, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/1/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Brooke Grove., | | 22d. LOCATION (City, town, or county) (State) Laytonsville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sumner ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR DATE JUN 13 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

52

1947-1948

1947-1948

1947-1948

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6055 CERTIFICATE OF DEATH

06007

Reg. Dist. No.....

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Montgomery</u> | | STATE <u>MARYLAND</u> | | STATE <u>D.C.</u> | | COUNTY <u>✓</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | LENGTH OF STAY (in this place)
<u>24 1/2 Hrs.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | | <u>47X-3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Suburban</u> | | | | STREET ADDRESS
<u>3722 T. St. N.W.</u> | | (If rural give location) | |
| 3. NAME OF DECEASED
(Type or Print) <u>Frank Aloysius Smith</u> | | | | 4. DATE OF DEATH
(Month) <u>May</u> (Day) <u>16</u> (Year) <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | | 8. DATE OF BIRTH
<u>12/9/00</u> | |
| 9. AGE last birthday
<u>59</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>William F. Smith</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Conley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>Navy</u> | | 17. INFORMANT & ADDRESS
<u>Same as Above</u>
<u>Wife (Mrs. Bessie Smith)</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 157X IMMEDIATE CAUSE (A) <u>Adenocarcinoma, Cancerous</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>8 mos.</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1942 May 16, 1960</u> , to <u>May 16, 1960</u> , that I last saw the deceased alive on <u>May 16, 1960</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>L. L. L. L.</u> | | | | DATE SIGNED
<u>13000-GEORGIA AVE. S.S.M.D. 5/16/60</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>BURIAL</u> | | DATE THEREOF
<u>5-19-60</u> | | NAME OF CEMETERY OR CREMATORY
<u>ARLINGTON NATIONAL</u> | | LOCATION (City, town, or county) (State)
<u>ARLINGTON, VIRGINIA</u> | |
| 24. REC'D BY REGISTRAR
<u>MAY 17 '60</u> | | REGISTRAR'S SIGNATURE
<u>Charles S. Hines</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>WASH. D.C.</u>
<u>Hyang Funeral Home 1300 N. ST. N.W.</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

Common notified & will appear

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | |
| 6056 Items 17, 23, 24, 26, 46-6-60 et | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights
c. LENGTH OF STAY IN 1b
58 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights
d. STREET ADDRESS 6106 Mass. Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) MINERVA
First A Middle Smith Last
4. DATE OF DEATH May 21 1960
Month May Day 21 Year 1960 | | 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 6, 1876
9. AGE (In years lost birthday) 83 yrs. Months 7 Days 15 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Indiana | | | 12. CITIZEN OF WHAT COUNTRY? US | | |
| 13. FATHER'S NAME John Ratliff | | | | 14. MOTHER'S MAIDEN NAME Unkn Sarah Ratliff | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 565-30-2370 | | 17. INFORMANT Thyra Mark-Daughter-same as 2d
Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute left ventricular Failure
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myocardial Infarction
DUE TO (c) Coronary Arteriosclerosis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 hrs.
3 hrs
10 years + | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aortic Aneurysm | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from March 27, 1960 to May 21, 1960 that (I) (was) last saw the deceased alive on May 21, 1960 and that death occurred at 12:00 AM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE William O. Bailey Jr.
22c. PHYSICIAN'S NAME (Type) William O. Bailey Jr. MD 2015 R St. N.W. Wash. D.C. | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 5/21/60 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit | | 23b. DATE THEREOF 5/26/60 | | 23c. NAME OF CEMETERY OR CREMATORY Des Moines Masonic Cem. | | 23d. LOCATION (City, town, or county) (State) Des Moines, Iowa | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey
ADDRESS Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR MAY 24 '60
DATE | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

58

(M)

(1)

Monography

John Schaefer

1000 Massachusetts Avenue

John Schaefer

1000 Massachusetts Avenue

London

London

John Schaefer

John Schaefer

1000 Massachusetts Avenue

No

John Schaefer

John Schaefer

John Schaefer

John Schaefer

John Schaefer

John Schaefer

John Schaefer

John Schaefer

John Schaefer

John Schaefer

John Schaefer

John Schaefer

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6057

CERTIFICATE OF DEATH

46009

Item 9 Film 0263 5-19-60 et

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING, Md. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SANDY SPRING, Md. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GEN. HOSP. | | | | d. STREET ADDRESS 1 CLARY, Md. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) ROBERT E. LEE SMITH | | | | 4. DATE OF DEATH 5 10 19 60 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-1-94 | |
| 9. AGE (In years last birthday) 47 62 yrs. | | 10. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME St. GEORGE SMITH | | | | 14. MOTHER'S MAIDEN NAME GEORGE MOSS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) World War I | | | | 16. SOCIAL SECURITY NO. — | | | |
| 17. INFORMANT Marie E. Smith Address wife SANDY SPRING MD. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) OSTEOGENIC SARCOMA WITH METASTASIS
196.9 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from OCTOBER 1959 to MAY 10 1960 , that (I) (we) last saw the deceased alive on 5-10 1960 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE A. D. Bonifant | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT | | | | 22d. ADDRESS Montgomery 2000 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| Burial | | 5/13/60 | | Rock Creek | | Washington, D.C. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home | | | | 25a. REC'D BY REGISTRAR May 16 '60 | | | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Haines | | | | | | | |

X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5897

CERTIFICATE OF DEATH

Reg. Dist. No.

46010

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY Montg. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 525 Orchard Way. | | d. STREET ADDRESS 525 Orchard Way | |
| 3. NAME OF DECEASED (Type or print) CHARLES HENRY SMOOT | | 4. DATE OF DEATH
Month 5 Day 24 Year 1960 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-18-1871 |
| 9. AGE (In years, day, month, and year)
yrs. 88 Months 5 Days 24 Hours 19 Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME George Smoot | | 14. MOTHER'S MAIDEN NAME Susan Cobey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Mrs Melissa Phillips | | Address 525 Orchard Way Sp. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Generalized
DUE TO (c) 5 yrs | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 19 60 , to 5/24 , 19 60 , that I last saw the deceased alive on 5/21 , 19 60 , and that death occurred at 7:30 P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. H. L. Hogan | | ADDRESS (Street, city or town, state) Sandy Spring, Md. | |
| PHYSICIAN'S NAME (Type) C. H. L. Hogan | | DATE SIGNED 5/24/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 5/27/60 | 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | 22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska | | 24a. REC'D BY REGISTRAR MAY 31 '60 | |
| ADDRESS SILVER SPRING, MD. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

322

14

6058

CERTIFICATE OF DEATH

66011

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Margina b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 4 Hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First David Middle E Last Spaulding | | 4. DATE OF DEATH Month May Day 9 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/29/93 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rate Analyst | 11. BIRTHPLACE (State or foreign country) Lowell Mass |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME Frank Spaulding | |
| 14. MOTHER'S MAIDEN NAME Anna Lovely | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Address Wife Mrs. Mina Spaulding (Same as Above) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Posterior Myocardial Infarction
DUE TO Thrombosis, Posterior Coronary artery
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Coronary Arteriosclerosis
DUE TO (c) Diabetes mellitus | | INTERVAL BETWEEN ONSET AND DEATH 1 Day
1 Day
Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 4, 1959 , to May 9, 1960 , that I last saw the deceased alive on May 8, 1960 , and that death occurred at 3:30 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Robert D. Harell | | ADDRESS (Street, city or town, state) 5526 Neb. Ave. D.C. 5-7-60 | |
| PHYSICIAN'S NAME (Type) Robert B. Havell | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 5/12/1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State) Prince Georges County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE SH Humes Co | | ADDRESS 2901 14th St NW | |
| 24a. REC'D BY REGISTRAR DATE MAY 10 '60 | | 24b. REGISTRAR'S SIGNATURE Charles S. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1000

CERTIFICATE OF DEATH

1000

| | | | | | |
|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | |
| Date of Birth | | Date of Death | | Place of Death | |
| Cause of Death | | Manner of Death | | Occupation | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | |
| Date of Certificate | | Place of Certificate | | Name of Registrar | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5918 **CERTIFICATE OF DEATH**

06012

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>6 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>George</u> Middle <u>Washington</u> Last <u>Stalcup</u> | | 4. DATE OF DEATH
Month <u>5</u> - Day <u>5</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-17-80</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <u>Mgr. Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Goods Store</u> | 9. AGE (In years last birthday) <u>79</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Stalcup</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Taylor</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.0</u> <u>Left sided congestive heart failure</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Intertrochanteric fracture left hip</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell in nursing home</u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> 19 <u>60</u> to <u>5-5</u> 19 <u>60</u> , that (I) (he) last saw the deceased alive on <u>5-5-60</u> 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Henry W. Jaeger M.D.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Henry W. Jaeger M.D.</u> | | 22d. ADDRESS <u>925 Pershing Dr. Silver Spring Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>5/9/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>WANNER E. DUMPHREY, INC.</u> | | 25a. REC'D BY REGISTRAR <u>MAY 9 '60</u> | |
| ADDRESS <u>SILVER SPRING, MD.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1918

1. Name of deceased William J. ...
2. Sex Male
3. Age 25
4. Date of death Aug 10 1918
5. Place of death ...
6. Cause of death ...
7. Signature of physician ...
8. Signature of registrar ...
9. Signature of coroner ...
10. Signature of undertaker ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6059

CERTIFICATE OF DEATH

06013

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Georgia b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fairburn 49x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS
Route # 1, Spense Road | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Wayne Last Stanley | | 4. DATE OF DEATH
Month May Day 27 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 16, 1952 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None (Student) | | 10b. KIND OF BUSINESS OR INDUSTRY
None | 9. AGE (In years last birthday) yrs. 8 |
| 11. BIRTHPLACE (State or foreign country)
Georgia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Andrew Stanley | | 14. MOTHER'S MAIDEN NAME
Marverneen Rowe | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
754.2 DUE TO Following open heart correction of Ventricular Septal defects
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Ventricular septal defect
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
36 hours
8 years | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 24 , 19 60 , to May 27 , 19 60 , that I last saw the deceased alive on May 27 , 19 60 , and that death occurred at 3:10A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Roland Folse, M.D. | | ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/27/60 | |
| PHYSICIAN'S NAME (Type) Roland Folse, M.D. | | National Institutes of Health
Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF
5/28/60 | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) La |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Frozier's Funeral Home, Inc | | 24a. REC'D BY REGISTRAR
DATE JUN 2 '60 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kima |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

033

| | | | | | | | | | |
|------------------------|--|-----------------------|--|------------------------|--|----------------------|--|-------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 12-1-28 | |
| PLACE OF BIRTH | | DATE OF DEATH | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | |
| MEMPHIS, TENN. | | 4-4-68 | | 10:00 PM | | HEART DISEASE | | NATURAL | |
| OCCUPATION | | EDUCATION | | RELIGION | | MARITAL STATUS | | SINGLE | |
| ATTORNEY | | HIGH SCHOOL | | METHODIST | | MARRIED | | MARRIED | |
| PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | |
| NONE | | NONE | | NONE | | NONE | | NONE | |
| PHYSICIAN'S NAME | | HOSPITAL NAME | | HOSPITAL ADDRESS | | HOSPITAL CITY | | HOSPITAL STATE | |
| DR. J. H. HARRIS | | MEMPHIS HOSPITAL | | 500 S. GAY | | MEMPHIS | | TENN. | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | | SIGNATURE OF CORONER | | SIGNATURE OF JURY | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| 4-4-68 | | 4-4-68 | | 4-4-68 | | 4-4-68 | | 4-4-68 | |

6060
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Dist. of Columbia b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | d. STREET ADDRESS 5025 - 42nd. St. N.W. | | | |
| 3. NAME OF DECEASED (Type or print)
First Etta Middle V. Last Stinchcomb | | | | 4. DATE OF DEATH
Month May Day 21 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept 18, 1892 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 9. AGE (In years last birthday) 67 yrs. | |
| 13. FATHER'S NAME JAMES WARING | | | | 14. MOTHER'S MAIDEN NAME SPRIGGS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 579-26-1527 | | 17. INFORMANT Elder T. Stinchcomb, Wash. D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of uterus Metastases
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, terminal due to carcinoma obstructing ureters | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 20g. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from 3:31 , 1949, to 5:21 , 1960, that I last saw the deceased alive on 5:20 , 1960, and that death occurred at 3:15 a.m. from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) 3921 Ingomar St. NW Wash. D.C. | | | | DATE SIGNED 5/21/60 | | | |
| ACTUAL SIGNATURE Stewart Clapp | | | | M.D. 3921 Ingomar St. NW Wash. D.C. | | | |
| PHYSICIAN'S NAME (Type) Stewart Clapp | | | | ADDRESS Wash. D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 23, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Asbury Met. Church Cem. | | 22d. LOCATION (City, town, or county) Arnold, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Chas. Chase | | | | ADDRESS 303 Wisconsin Wash. D.C. | | 24a. REC'D BY REGISTRAR Wm. S. Hume | |
| DATE MAY 24 '60 | | | | 24b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6061

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>XXXXX Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Wheaton</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>57 WASHINGTON 16 - Sumner</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Wheaton Nursing Home</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>May</i> Middle <i>Lawton</i> Last <i>Sweet</i> | | 4. DATE OF DEATH
Month <i>May</i> Day <i>28</i> Year <i>1960</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>Wh</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Oct. 15 1869</i> |
| 9. AGE (In years last birthday)
<i>90</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>H.s.wf.</i> | 11. BIRTHPLACE (State or foreign country)
<i>Rhode Island</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 13. FATHER'S NAME
<i>Thomas Lawton</i> | |
| 14. MOTHER'S MAIDEN NAME
<i>Ellen Vase</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<i>No</i> | |
| 16. SOCIAL SECURITY NO.
<i>None</i> | | INFORMANT
<i>Theodore L. Sweet</i> Address <i>Same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Decompensation,</i>
DUE TO <i>Arteriosclerotic Heart Disease,</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i>
DUE TO (c) <i>Inanition, - based on senility.</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 Hours.</i>
<i>10+ years.</i>
<i>20+ years.</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>1952</i> , 19____, to <i>5-28</i> , 19____, that I last saw the deceased alive on <i>5-27</i> , 19____, and that death occurred at <i>3 p. M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>James W. Long</i> | | ADDRESS (Street, city or town, state)
<i>6601 Greentree Rd, Beth, Md.</i> | |
| PHYSICIAN'S NAME (Type)
<i>James W. Long</i> | | DATE SIGNED
<i>May 28, 1960.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial Trans</i> | 22b. DATE THEREOF
<i>5/29/60</i> | 22c. NAME OF CEMETERY OR CREMATORY
<i>Swann Bent</i> | 22d. LOCATION (City, town, or county) (State)
<i>Providence Rhode Island</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Robert A. Humphrey</i> | | 24a. REC'D BY REGISTRAR
DATE <i>JUN 1 '60</i> | |
| ADDRESS
<i>Beth Md.</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kneass</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

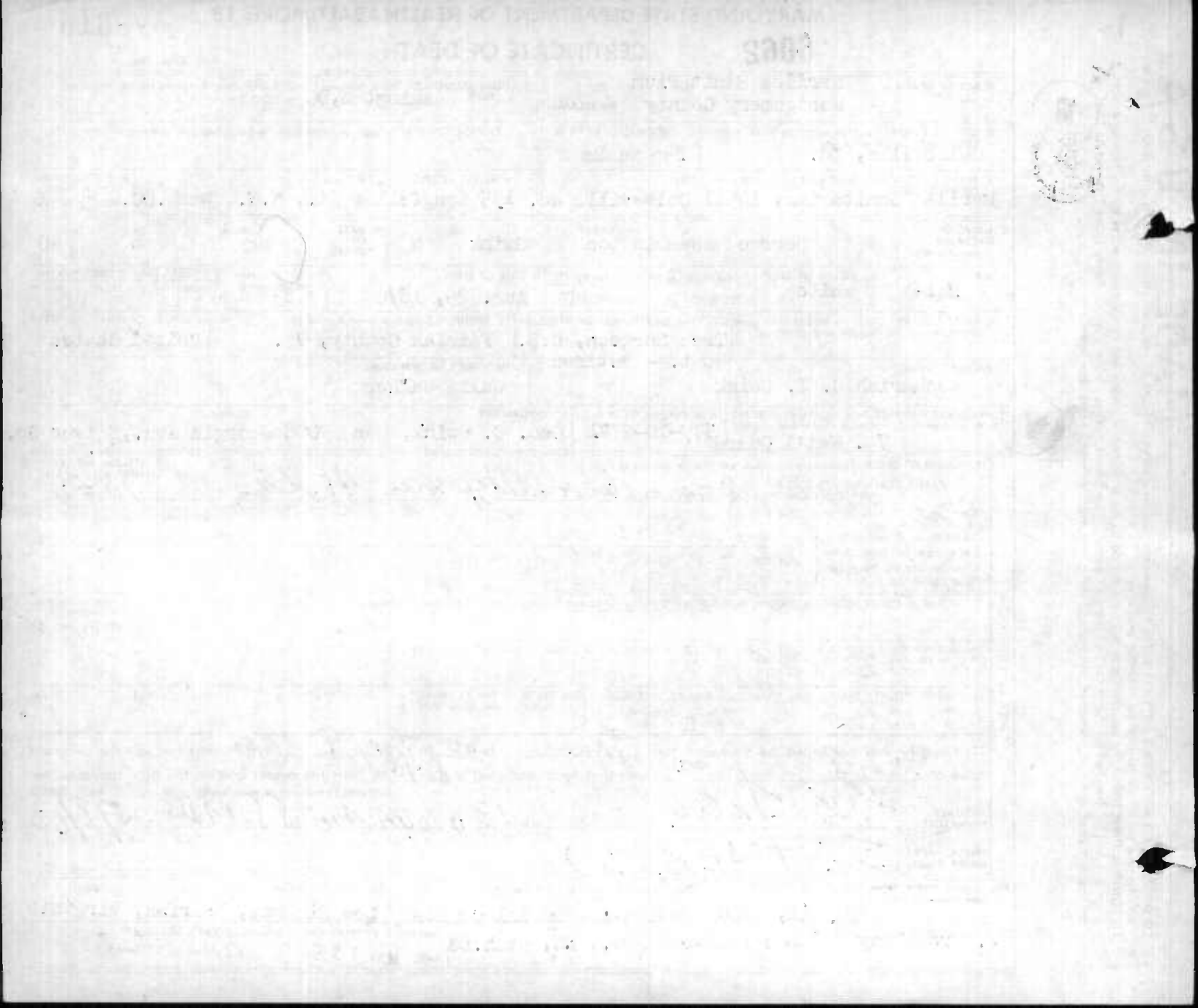
57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 6016 | |
|--|--|---------------------------|---|---|--|--|--------------------------------------|---|---|--|--|
| 6062 | | | | | | | | | | CERTIFICATE OF DEATH | |
| Reg. Dist. No. | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY | | | Marilea Sanitarium
Montgomery County MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Washington, DC b. COUNTY | | | | ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Colesville, Md. | | | c. LENGTH OF STAY IN 1b
Two weeks | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
47X-3 | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Marilea Sanitarium, 14511 Colesville Rd. | | | d. STREET ADDRESS
135 Longfellow St., N.W., Wash. DC. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) | | | First George Middle Washington Last Swink | | | 4. DATE OF DEATH
Month May Day 8 Year 19 60 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 25, 1876 | | 9. AGE (In years last birthday) yrs.
83 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY
Tree Surgeon, U.S. Govt. - Retired | | | 11. BIRTHPLACE (State or foreign country)
Fairfax County, Va. | | | 12. CITIZEN OF WHAT COUNTRY?
United States | | |
| 13. FATHER'S NAME
Zachariah C. T. Swink | | | 14. MOTHER'S MAIDEN NAME
Julia Walker | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
Va. Nat'l Guard | | | 16. SOCIAL SECURITY NO.
579-10-2791 | | | INFORMANT
Address
Geo. C. Swink, Son 9008 Georgia Ave., Silver Sp. Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 DUE TO <i>asthma 13 years Ht. Lcs.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs. INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from Jan 19 60, that I last saw the deceased alive on May 8 19 60, and that death occurred at 8:40 M. from the causes and on the date stated above.
P. L. Sallie
S. L. TABB, M.D.
ADDRESS (Street, city or town, state) M.D. 13000 94 AVE S. I. D. 5/8/60
DATE SIGNED | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | 22b. DATE THEREOF
May 11, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY
National Memorial Cemetery | | | 22d. LOCATION (City, town, or county) (State)
Lee Highway, Fairfax, Virginia | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. Frank Joy | | | ADDRESS
5406 Illinois Ave., NW, Wash. DC | | | 24a. REC'D BY REGISTRAR
DATE MAY 13 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66017

Reg. Dist. No.

| | | | | | |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hosp. | | | d. STREET ADDRESS
RFD # 3 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
Claude Victor Tennery | | | 4. DATE OF DEATH
May 3, 1960 | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/31/91 | | 9. AGE (In years last birthday)
69 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Line type operator Printing | | 10b. KIND OF BUSINESS OR INDUSTRY
OKlahoma | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A | |
| 13. FATHER'S NAME
not known | | | 14. MOTHER'S MAIDEN NAME
not known | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Charlotte Tennery | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Thrombosis, Post. coronary artery
(c) Coronary arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
sudden | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Multiple fracture - Ruptured heart | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Was driven into which struck parked truck | | | |
| 20c. TIME OF INJURY
Month, Day, Year
4:30 Hour XX p. m. 5/3/ 19 60 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
highway | |
| | | 20f. (City or town)
Garrett Pk. Montg. | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type)
Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 5/4/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-6-60 | | 22c. NAME OF CEMETERY OR CREMATORY
Park Lawn | |
| | | 22d. LOCATION (City, town, or county)
Rockville. Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
E. C. Partners | | 24a. REC'D BY REGISTRAR
316 E. Diamond Ave | | 24b. REGISTRAR'S SIGNATURE
May 9 '60 | |
| | | ADDRESS
Gaithersburg, Md. | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF MEDICAL EXAMINER | | 17. SIGNATURE OF JURY | | 18. SIGNATURE OF JURY | |
| 19. SIGNATURE OF JURY | | 20. SIGNATURE OF JURY | | 21. SIGNATURE OF JURY | |
| 22. SIGNATURE OF JURY | | 23. SIGNATURE OF JURY | | 24. SIGNATURE OF JURY | |
| 25. SIGNATURE OF JURY | | 26. SIGNATURE OF JURY | | 27. SIGNATURE OF JURY | |
| 28. SIGNATURE OF JURY | | 29. SIGNATURE OF JURY | | 30. SIGNATURE OF JURY | |
| 31. SIGNATURE OF JURY | | 32. SIGNATURE OF JURY | | 33. SIGNATURE OF JURY | |
| 34. SIGNATURE OF JURY | | 35. SIGNATURE OF JURY | | 36. SIGNATURE OF JURY | |
| 37. SIGNATURE OF JURY | | 38. SIGNATURE OF JURY | | 39. SIGNATURE OF JURY | |
| 40. SIGNATURE OF JURY | | 41. SIGNATURE OF JURY | | 42. SIGNATURE OF JURY | |
| 43. SIGNATURE OF JURY | | 44. SIGNATURE OF JURY | | 45. SIGNATURE OF JURY | |
| 46. SIGNATURE OF JURY | | 47. SIGNATURE OF JURY | | 48. SIGNATURE OF JURY | |
| 49. SIGNATURE OF JURY | | 50. SIGNATURE OF JURY | | 51. SIGNATURE OF JURY | |
| 52. SIGNATURE OF JURY | | 53. SIGNATURE OF JURY | | 54. SIGNATURE OF JURY | |
| 55. SIGNATURE OF JURY | | 56. SIGNATURE OF JURY | | 57. SIGNATURE OF JURY | |
| 58. SIGNATURE OF JURY | | 59. SIGNATURE OF JURY | | 60. SIGNATURE OF JURY | |
| 61. SIGNATURE OF JURY | | 62. SIGNATURE OF JURY | | 63. SIGNATURE OF JURY | |
| 64. SIGNATURE OF JURY | | 65. SIGNATURE OF JURY | | 66. SIGNATURE OF JURY | |
| 67. SIGNATURE OF JURY | | 68. SIGNATURE OF JURY | | 69. SIGNATURE OF JURY | |
| 70. SIGNATURE OF JURY | | 71. SIGNATURE OF JURY | | 72. SIGNATURE OF JURY | |
| 73. SIGNATURE OF JURY | | 74. SIGNATURE OF JURY | | 75. SIGNATURE OF JURY | |
| 76. SIGNATURE OF JURY | | 77. SIGNATURE OF JURY | | 78. SIGNATURE OF JURY | |
| 79. SIGNATURE OF JURY | | 80. SIGNATURE OF JURY | | 81. SIGNATURE OF JURY | |
| 82. SIGNATURE OF JURY | | 83. SIGNATURE OF JURY | | 84. SIGNATURE OF JURY | |
| 85. SIGNATURE OF JURY | | 86. SIGNATURE OF JURY | | 87. SIGNATURE OF JURY | |
| 88. SIGNATURE OF JURY | | 89. SIGNATURE OF JURY | | 90. SIGNATURE OF JURY | |
| 91. SIGNATURE OF JURY | | 92. SIGNATURE OF JURY | | 93. SIGNATURE OF JURY | |
| 94. SIGNATURE OF JURY | | 95. SIGNATURE OF JURY | | 96. SIGNATURE OF JURY | |
| 97. SIGNATURE OF JURY | | 98. SIGNATURE OF JURY | | 99. SIGNATURE OF JURY | |
| 100. SIGNATURE OF JURY | | 101. SIGNATURE OF JURY | | 102. SIGNATURE OF JURY | |

6064

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Garrett Park | | c. LENGTH OF STAY IN 1b
10 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
10923 Montrose Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First BELLA Middle BROOKS Last Thompson | | 4. DATE OF DEATH
Month May Day 24 Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/3/77 |
| 9. AGE (In years lost birthday) yrs.
83 | | 10. IF UNDER 1 YEAR
Months 2 Days 0 Hours 0 Min. 0 | 11. IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
School teacher, retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Pennsylvania | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WALTER J. BROOKS | | 14. MOTHER'S MAIDEN NAME
PHOEBE VIRGINIA BASSETT | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
Mr. Alex C. Adrian, 10,923 Montrose Ave. Garrett Park, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Exsanguination, Slow drainage rectal
DUE TO (b) Carcinomatosis, Abdomen, Chest
DUE TO (c) Carcinoma Rectum, Primary Site
INTERVAL BETWEEN ONSET AND DEATH 2 Months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March , 19 60 , to May 24 , 19 60 , that I last saw the deceased alive on May 21 , 19 60 , and that death occurred at 1:15 PM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 10609 Concord St. Kensington, Md. DATE SIGNED May 24, 1960 | | | |
| ACTUAL SIGNATURE Robert T. Thibadeau | | SIGNATURE OF REGISTRAR Arthur S. Kraus | |
| PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. | | ADDRESS Kensington, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
5/27/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEMETERY | | 22d. LOCATION (City, town, or county) (State)
WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Raymond A. Ziska | | 24a. REC'D BY REGISTRAR
DATE MAY 31 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12

1

1000

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON
c. LENGTH OF STAY IN 1b 9 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 SILVER SPRING
d. STREET ADDRESS 2713 HARMON ROAD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First EMMA Middle FROST Last TYLER | | 4. DATE OF DEATH
Month May Day 16 Year 1960 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/3/78 |
| 9. AGE (In years lost birthday) 81 | | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GLOVEMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY GLOVE MFG. CO. | |
| 11. BIRTHPLACE (State or foreign country) ENGLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME unknown FROST | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. yes | |
| 17. INFORMANT Mrs. Vera Abbaticchio, 2713 Harmon Rd. | | Address Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) ESSENTIAL HYPERTENSION
DUE TO
(c) GENERALIZED ARTERIOSCLEROSIS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 2, 1954 to May 16, 1960 , that I last saw the deceased alive on May 16, 1960 , and that death occurred at 8:35 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 5206 Norway Dr. DATE SIGNED Cherry Chase, Md. | | | |
| ACTUAL SIGNATURE Henry M. Lowden M.D. | | PHYSICIAN'S NAME (Type) HENRY M. LOWDEN | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL | | 22b. DATE THEREOF 5/17/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY FERN DALE CEMETERY | | 22d. LOCATION (City, town, or county) (State) FULTON COUNTY, NEW YORK | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE MAY 18 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Harris | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6065 CERTIFICATE OF DEATH

66020

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY HOWARD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
OLNEY | | | | c. LENGTH OF STAY IN 1b
3 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MONTGOMERY GENERAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First WALLAS Middle (Wallace) Last TYLER | | | | 4. DATE OF DEATH
Month MAY Day 18 Year 1960 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
COLORED | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1890 yrs. 70 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
WALLAS WILLIAMS | | | | 14. MOTHER'S MAIDEN NAME
LAURA ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
None | | 17. INFORMANT
HOSPITAL RECORDS Address OLNEY, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
3 DAYS | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JULY 1946 to MAY 18 1960 , that (I) (we) last saw the deceased alive on MAY 17 1960 , and that death occurred at 1:35 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>C. S. Whitaker, M. D.</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/18/60 | |
| 22c. PHYSICIAN'S NAME (Type)
C. S. WHITAKER, M. D. | | | | 22d. ADDRESS
CLARKSVILLE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-21-60 | | 23c. NAME OF CEMETERY OR CREMATORY
West Liberty | | 23d. LOCATION (City, town, or county) (State)
Alpha, Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
F.C. Higinbotham, Ellicott City, Md | | | | 25a. REC'D BY REGISTRAR
DATE MAY 23 '60 | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Hines</i> | |

CERTIFICATE OF DEATH

1908



RECEIVED
MAY 17 1908

U.S. DEPARTMENT OF HEALTH

2-21-08

ALBANY, N.Y.

CUNNINGHAM, M.

MAY 17

80

JULY

1908

MAY 13

85

1908

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

46021

Reg. Dist. No.

| | | | | | | | |
|---|---|---|------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONT GOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT GOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TAIKOMA PARK</u> | | c. LENGTH OF STAY IN 1b
<u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>235 Silver Spring</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>WASH. SAND HOSP.</u> | | | | 1d. STREET ADDRESS
<u>95 Wayne Ave</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Ruth</u> Middle <u>Jane</u> Last <u>Upchurch</u> | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>6</u> Year <u>1960</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-10-04</u> | 9. AGE (In years last birthday)
<u>56</u> yrs. | 10. IF UNDER 1 YEAR
Months <u>5</u> Days <u>6</u> | | 11. IF UNDER 24 HRS.
Hours <u>19</u> Min. <u>60</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Owner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Dress Shop</u> | | 11. BIRTHPLACE (State or foreign country)
<u>BROADWAY VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>George P. Grady</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Loua May Wilson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>420</u> | | 17. INFORMANT <u>Funeral Director</u>
<u>Mr. James F. Scarpelli, 108 Virginia Ave.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> sudden</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschek</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschek</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. DATE OF REMOVAL (Specify)
<u>5/6/60</u> | | 22b. DATE THEREOF
<u>5/6/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hillcrest Cemetery</u> | | 22d. LOCATION (City, town, or county) _____ (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Pumphrey, Inc.</u>
<u>Raymond A. Ziska</u> | | | | ADDRESS
<u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 9 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | | | |

MEDICAL CERTIFICATION

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any change is necessary, please execute a new certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G263 5/27/60 iwk
6066 CERTIFICATE OF DEATH

Reg. Dist. No.

66022

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 7, D.C.</i> | |
| c. LENGTH OF STAY IN 1b <i>2 yrs.</i> | | d. STREET ADDRESS <i>3850 Tunlaw Rd. N.W.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RESIDOR</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>CAROLINE</i> First <i>C</i> Middle <i>V</i> Last <i>VOIGT</i> | | 4. DATE OF DEATH Month <i>May</i> Day <i>23</i> Year <i>1960</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8/29/1874</i> |
| 9. AGE (In years last birthday) <i>85</i> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Valentine Waldkonig</i> | | 14. MOTHER'S MAIDEN NAME <i>Eliza. Alle</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>Charlotte Gower</i> | | 18. ADDRESS <i>3850 Tunlaw Rd. N.W. Washington, D.C.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinomatosis</i>
DUE TO (b) <i>Carcinoma of rectum</i>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. (c) <i>—</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic cardiovascular disease</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <i>—</i> p. m. <i>—</i> 19 <i>60</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Nov. 5-14</i> , 19 <i>57</i> , to <i>5/23</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5-14</i> , 1960, and that death occurred at <i>1:45 P.M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>H. D. Ecker</i> | | ADDRESS (Street, city or town, state) <i>917-20 St. N.W. Washington 6 D.C.</i> | |
| PHYSICIAN'S NAME (Type) <i>HENRY D. Ecker</i> | | DATE SIGNED <i>May 25 '60</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>5/25/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i> | | 24a. REC'D BY REGISTRAR <i>Arthur S. Hines</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>—</i> | | DATE <i>May 25 '60</i> | |

(14)

72

(1)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5928
CERTIFICATE OF DEATH

66023

| | | | |
|---|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
55 Chevy Chase | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4709 Cumberland Avenue | | d. STREET ADDRESS
4709 Cumberland Avenue | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Howard R Watkins | | 4. DATE OF DEATH
Month May Day 14 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/2/78 |
| 9. AGE (In years lost birthday)
82 yrs. | | IF UNDER 1 YEAR
Months 0 Days 12 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chemist-Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Chemistry | |
| 11. BIRTHPLACE (State or foreign country)
Iowa | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
William Watkins | | 14. MOTHER'S MAIDEN NAME
Mary Ball | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Nina Watkins-wife-same as 2d | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
1 day | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1950 to May 14, 1960 that (I) (we) last saw the deceased alive on May 13, 1960 , and that death occurred at 2 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Paul D. Cantor | | 22b. DATE SIGNED
5-14-60 | |
| 22c. PHYSICIAN'S NAME (Type)
Paul D. Cantor | | 22d. ADDRESS
4709 Montg. Lane, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/16/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City, town, or county) (State)
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | 25a. REC'D BY REGISTRAR
MAY 17 '60 | |
| ADDRESS
Bethesda, Maryland | | 25b. REGISTRAR'S SIGNATURE
C. L. Hanna | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06024

5920

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> | | | |
| c. LENGTH OF STAY IN 1b <u>55 days</u> | | | | d. STREET ADDRESS <u>219 N. Park Dr.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Eucy Fitzhugh Watkins</u> | | | | 4. DATE OF DEATH <u>May - 21 1960</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-10-93</u> | |
| 9. AGE (In years, last birthday) <u>66</u> yrs. | | 10. UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | | |
| 13. FATHER'S NAME <u>Everett Whaley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Frances Cross</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT Address <u>Hospital Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Echthymia and aneurysm</u>
DUE TO <u>170X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of Breast with metastasis to lymph</u>
DUE TO <u>Cancer of Breast</u>
(c) <u>Cancer of Breast</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr -</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/30/1960</u> to <u>5/20/1960</u> that (I) (we) last saw the deceased alive on <u>5/20/1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Chas H Wolothon, MD</u> | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolothon, MD</u> | |
| 22d. ADDRESS <u>2600 Lowell Ave. Silver Spring, Md</u> | | | | 22e. REC'D BY REGISTRAR | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/24/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. - Arlington, Virginia</u> | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Hines Co</u> | | | | ADDRESS <u>2901-14 45th St. N.W. Wash, DC</u> | | 25a. REC'D BY REGISTRAR DATE <u>MAY 23 '60</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles E. Kiser</u> | | | |

1883

CENTRAL STATE OF TEXAS

1883

The undersigned, *John W. Wells*,
 of the County of *Wichita*, State of *Kansas*,
 do hereby certify that the within and foregoing
 is a true and correct copy of the original
 as the same appears from the records of the
 County of *Wichita*, State of *Kansas*.

1120

Witness my hand and seal of office
 this *11th* day of *April*, 1883.
 John W. Wells, County Clerk

1883

MADE IN U.S.A.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6067 CERTIFICATE OF DEATH

66025

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE D.C. b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME | | | | d. STREET ADDRESS 4447 P. St. N.W. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First RANDOLPH Middle WEHLER Last WEHLER | | | | 4. DATE OF DEATH Month 5 Day 13 Year 1960 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb 24 1866 | |
| 9. AGE (In years last birthday) 94 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist | | | | 10b. KIND OF BUSINESS OR INDUSTRY Drug Store | | 11. BIRTHPLACE (State or foreign country) PENNA (Adams Co.) | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Levi Wehler | | | | 14. MOTHER'S MAIDEN NAME Katherine Mummert | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. none | | | |
| INFORMANT Address Washington | | | | J. Ross Wolfe-4447 P St. N.W. D. C. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic heart failure
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis
DUE TO
(c) years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Dec 56 , to present , 19 60 , that I last saw the deceased alive on May 62 , 19 60 , and that death occurred at 3 P. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 4400-49 St NW Washington 16 DC DATE SIGNED 5-13-60
ACTUAL SIGNATURE C P Ryland M.D. C P RYLAND
PHYSICIAN'S NAME (Type) C P RYLAND | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 5/17/60 | | New Oxford Cemetery | | New Oxford, Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W. | | | | 24a. REC'D BY REGISTRAR MAY 16 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

6883

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5898 CERTIFICATE OF DEATH

06026

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|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | c. LENGTH OF STAY IN 1b
Since 9/59 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
15 SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
826 BONIFANT STREET | | | | d. STREET ADDRESS
1 826 BONIFANT STREET | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle McDONALD Last WEINGARTH | | | | 4. DATE OF DEATH
Month 5 Day 17 Year 19 60 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/26/76 | |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | | 11. BIRTHPLACE (State or foreign country)
Kansas | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John P. McDonald | | | | 14. MOTHER'S MAIDEN NAME
Mary Ann Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
none | | 17. INFORMANT Address
Mrs. Peter N. Benedict, 826 Bonifant St. Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
163X Metastatic Ca of Lung
DUE TO (a)
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Generalized arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State)
Jan 58 May 60 | |
| 21. I certify that (I) (this hospital) attended the deceased from 5-16 19 60 to May 58 19 60 , that (I) was last saw the deceased alive on 5-16 19 60 , and that death occurred at 5:30 A.M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Bernard A. Fitzgerald | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
BERNARD A. FITZGERALD | | | | 22d. ADDRESS
217 University Blvd E, S.S., Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
TRANS. & BURIAL | | 23b. DATE THEREOF
5/20/60 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. CALVARY CEMETERY | | 23d. LOCATION (City, town, or county) (State)
LEAVENWORTH, KANSAS | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Raymond E. Pumphrey, INC. | | | | ADDRESS
SILVER SPRING, MD. | | 25a. REC'D BY REGISTRAR
MAY 18 '60 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |



Notice to the public

Franklin County

John H. Hays

John H. Hays

John H. Hays

John H. Hays

John H. Hays

John H. Hays

5929

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CHEVY CHASE | | c. LENGTH OF STAY IN lb | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4709 LANGDRUM LANE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CHEVY CHASE 55
d. STREET ADDRESS
4709 LANGDRUM LANE 1 | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First BERNARD Middle WEITZER Last | | 4. DATE OF DEATH
Month MAY Day 1 Year 19 60 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 28, 1891 |
| 9. AGE (In years last birthday)
68 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
EDUCATION DIRECTOR | | 10b. KIND OF BUSINESS OR INDUSTRY
JEWISH WAR VETS. | 11. BIRTHPLACE (State or foreign country)
NEW YORK |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
HYMAN WEITZER | | 14. MOTHER'S MAIDEN NAME
SARA LIFSTEIN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes, give war or dates of service)
WW-I | | 16. SOCIAL SECURITY NO.
068-01-1011 | |
| INFORMANT
EVA BONNER WEITZER | | Address
4709 LANGDRUM LANE., CHEVY CHASE, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH,
5 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Coronary atherosclerosis + atherosclerotic changes | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1, 1960 to May 1, 1960 that I last saw the deceased alive on May 1, 1960 , and that death occurred at 9:00 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Orville W. Donnelly M.D. | | ADDRESS (Street, city or town, state)
1035 Vermont Ave NW, Washington 5, D.C. | |
| DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type)
ORVILLE W. DONNELLY, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
5-3-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREMATORY | | 22d. LOCATION (City, town, or county) (State)
SUITLAND, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
BERNARD DANZANSKY & SONS | | ADDRESS
3501 14th St. N.W. | |
| 24a. REC'D BY REGISTRAR
DATE MAY 4 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hines | |

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06028

5921 Item 13 Film 264 8-6-60 et

| | | | | | | | |
|---|---------------------------|--|--|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>Penn.</u> b. COUNTY <u>Centre</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u> | | | | c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u> | | | | d. STREET ADDRESS <u>—</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Victor Stansbury Weston</u> | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>31</u> Year <u>1960</u> | | | |
| 5. SEX <u>m</u> | 6. COLOR OR RACE <u>w</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-8-77</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter & Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Penn.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME (First name unknown) <u>Weston</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lydia</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>WH2-2737 2719 Hindell ST. Glenmont Pennsylvania</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u>
DUE TO (c) <u>Generalized arteriosclerosis</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u>
p.m. <u>—</u> | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Nat. while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>22 May 1960</u> to <u>31 May 1960</u> , that (I) (we) last saw the deceased alive on <u>30 May 1960</u> , and that death occurred at <u>12 noon</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Merton L. White</u> | | | | 22b. DATE SIGNED <u>31 May 60</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Merton L. White</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 23b. DATE THEREOF <u>June 4, 1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterians Cemetery</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. Pumphrey</u> | | | | 25a. REC'D BY REGISTRAR <u>Arthur S. Hume</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

STATE OF TEXAS
COUNTY OF DALLAS

1991

Know all men by these presents, that _____ of the County of _____ State of _____ do hereby certify that _____ of the County of _____ State of _____ is the owner of the following described land, to-wit:

AS:

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.D. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|-------------------------------|---|--|--|--|---|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 5895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 66029 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
c. LENGTH OF STAY IN 1b <u>8 mo</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9212 Wendell St</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>montg</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>22 Silver Spring</u>
d. STREET ADDRESS <u>9212 Wendell St</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Adela Hedwig Wetzel</u> | | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>3</u> Year <u>1960</u> | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-21-1884</u> | | 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> IF UNDER 24 HRS. Hours <u>3</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | 11. BIRTHPLACE (State or foreign country) <u>Minn.</u> | | | | |
| 13. FATHER'S NAME <u>Henry Streich</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Phyllis W. Spam - Streich</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) | | | | | 17. INFORMANT <u>Phyllis W. Spam - Streich</u> Address <u>Stam 2</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>none</u> | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>
DUE TO (b) <u>331X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| | | | | | Address (Street, city, town, or county) <u>523-60</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | | 22b. DATE THEREOF <u>5/5/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> | | 22d. LOCATION (City, town, or country) (State) <u>Winona, Minnesota</u> | | |
| 23. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u> | | | | | | 24a. REC'D BY REGISTRAR <u>MAY 5 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |

THE STATE
OF NEW YORK

1880

THE STATE OF NEW YORK
IN SENATE
January 1, 1880

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1879

ALBANY: PUBLISHED BY THE STATE PRINTING OFFICE, 1880.

Price, 25 CENTS.

NEW YORK: 1880.

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NEW YORK: 1880.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66030

Reg. Dist. No.

6068

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hosp. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Marian Whinnery White | | 4. DATE OF DEATH
May 9, 1960 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/10/75 |
| 9. AGE (In years last birthday)
84 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | |
| 11. BIRTHPLACE (State or foreign country)
Ill | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Whinnery | | 14. MOTHER'S MAIDEN NAME
Annie Kinley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Hosp. Record | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration of Gastric Contents
DUE TO (b) Intestinal Obstruction
DUE TO (c) Carcinoma of Rectum | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
2 Days
Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell from hospital bed | |
| 20c. TIME OF INJURY
Month, Day, Year
May 8 & 9
Hour
8:50 P.M. & 3:15 AM | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
hosp | | 20f. (City or town) (County) (State)
Bethesda Montg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
5/10/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) (State)
Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | 24a. REC'D BY REGISTRAR
May 11 '60 | |
| ADDRESS
Bethesda, Maryland | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kears | |

STATE OF MARYLAND
JULY 1960

50

STATE OF MARYLAND

STATE OF MARYLAND
JULY 1960

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6068

| | | | | | | | |
|---------------------------------------|--|--------------------------------------|--|---------------------------------------|--|---------------------------------------|--|
| NAME OF DECEASED
JAMES H. HARRIS | | AGE
68 | | SEX
Male | | RACE
White | |
| DATE OF DEATH
July 1, 1960 | | PLACE OF DEATH
Home | | CITY
Baltimore | | COUNTY
Baltimore | |
| OCCUPATION
Retired | | EDUCATION
High School | | MARRIAGE
Married | | RELIGION
Roman Catholic | |
| PREVIOUS ILLNESS
None | | CAUSE OF DEATH
Heart Failure | | MANNER OF DEATH
Natural | | SIGNATURE OF EXAMINER
J. H. Harris | |
| DATE OF EXAMINATION
July 1, 1960 | | PLACE OF EXAMINATION
Home | | CITY
Baltimore | | COUNTY
Baltimore | |
| SIGNATURE OF DECEASED
J. H. Harris | | SIGNATURE OF WITNESS
J. H. Harris | | SIGNATURE OF EXAMINER
J. H. Harris | | SIGNATURE OF ATTORNEY
J. H. Harris | |
| DATE OF SIGNATURE
July 1, 1960 | | DATE OF SIGNATURE
July 1, 1960 | | DATE OF SIGNATURE
July 1, 1960 | | DATE OF SIGNATURE
July 1, 1960 | |

CERTIFICATE OF DEATH

Reg. Dist. No.

06031

| | | | | | | | |
|---|------------------------------|---|---|--|--|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BETHESDA
MONT GOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE North Dakota b. COUNTY Solingen Valley | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beech | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6004 Ruby | | | | d. STREET ADDRESS Not known | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
BLACHE LYNN WHITEMORE | | | | 4. DATE OF DEATH
Month Day Year
May 16 1960 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
29 Oct 1877 | 9. AGE (In years last birthday)
82 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JAMES LYNN | | | | 14. MOTHER'S MAIDEN NAME
HATTIE GURK | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
at home | | 17. INFORMANT
MRS DON SHORT - Bethesda | | Address 6004 Ruby Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
153.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) IN ANAETION
DUE TO (c) CARCINOMA OF COLON | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 mos
4 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
ARTERIO-SCLEROTIC HEART DISEASE | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 1958 , to MAY 1960 , that I last saw the deceased alive on MAY 13, 1960 , and that death occurred at 5:30 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William Henry Killay M.D. | | | | ADDRESS (Street, city or town, state) 9902 COUNSEL-MARK DATE SIGNED BETHESDA 17 MAY 1960 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Bur-Transit | | 22b. DATE THEREOF
5/19/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | | 22d. LOCATION (City, town, or county) (State)
Burley Co. North Dakota | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphtey | | | | ADDRESS
Bethesda, Maryland | | 24a. REC'D BY REGISTRAR
MAY 17 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Clifton L. Hume | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6070

06032

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
44 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
9316 Elmhurst Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Dee Middle C Last Will | | 4. DATE OF DEATH
Month May Day 18 Year 19 60 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/4/1887 |
| 9. AGE (In years lost birthday) yrs. 72 | | IF UNDER 1 YEAR: Months 11 Days 14 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 11. BIRTHPLACE (State or foreign country)
Texas | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. John Edy-daughter-same | | Address
2d | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, terminal
154X DUE TO Metastatic Carcinoma, peritoneal
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cloacal Cell Carcinoma of rectum
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
2 years
3 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 13 1952 to May 18 1960 , that (I) (we) last saw the deceased alive on May 18 1960 , and that death occurred at 1230 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Robert G. Angle | | 22b. DATE SIGNED
May 19, 1960 | |
| 22c. PHYSICIAN'S NAME (Type)
Robert G. Angle, M.D. | | 22d. ADDRESS
5009 Del Ray Avenue, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
5/23/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City, town, or county) (State)
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | 25a. REC'D BY REGISTRAR
Bethesda, Maryland | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Travis | | DATE
MAY 24 '60 | |

44

0030

OFFICE OF THE

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No

None

None

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Department

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

VS. A15ME
5M 7/59

| Item 18 Film 263 5-2760 | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | |
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | | | |
| 6071 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 66033 | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)
c. LENGTH OF STAY IN 1b
1 hr.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
U. S. Naval Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Virginia
b. COUNTY
Quantico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Marine Corps Schools
d. STREET ADDRESS
Marine Corps Schools
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Frank WILLIAMS | | | | | 4. DATE OF DEATH
Month May Day 14 Year 19 60 | | | | | | | | | | | | | | |
| 5. SEX
Male | | | | | 6. COLOR OR RACE
Negro | | | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | |
| 8. DATE OF BIRTH
6-16-24 | | | | | 9. AGE (In years last birthday)
35 yrs. | | | | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | | | | | | | | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U. S. Marine Corps | | | | | 11b. KIND OF BUSINESS OR INDUSTRY
- - - - - | | | | | 11. BIRTHPLACE (State or foreign country)
Louisiana | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | 13. FATHER'S NAME
Abe WILLIAMS | | | | | 14. MOTHER'S MAIDEN NAME
Joeanna (unknown) | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes 1943 to DOD | | | | | 16. SOCIAL SECURITY NO.
435-20-6378 | | | | | 17. INFORMANT
Hospital Records | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Epidural hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple injuries
DUE TO (c) Auto accident | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 hrs. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Was driver of automobile which struck bridge abutement | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
5:30 a.m. May 14 19 60 | | | | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Shirley Highway | | | | | | | | | |
| 20f. (City or town)
1.2 mi. south Rt. 617 Virginia | | | | | 20g. (County)
Virginia | | | | | 20h. (State)
Virginia | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | | | | M.D. | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| EXAMINER'S NAME (Type)
Frank J. Broschart, M.D. | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | |
| DATE SIGNED
5-14-60 | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Shipment | | | | | 22b. DATE THEREOF
5-16-60 | | | | | 22c. NAME OF CEMETERY OR CREMATORY
Port Hudson National Cemetery Zachary Louisiana | | | | | | | | | |
| 22d. LOCATION (City, town, or country)
Louisiana | | | | | 22e. (State)
Louisiana | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR
W.W. Chamber 1400 Chapin St. N.E. Washington D.C. | | | | | ADDRESS
W.W. Chamber 1400 Chapin St. N.E. Washington D.C. | | | | | 24a. REC'D BY REGISTRAR
Joseph B. Henderson | | | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE
Joseph B. Henderson | | | | | DATE
5-15-60 | | | | | | | | | | | | | | |

MAY 19 '60

Arthur S. Kraus

100-100000
100-100000



100-100000

Virginia

united

100-100000

Canada (Bent)

U. S. Naval Hospital

Marine Corps School

WILLIAM

100-100000

negro

100-100000

U. S. Marine Corps

Louisiana

Joanna (Lambert)

100-100000

100-100000

was driver of automobile which struck bridge support

May 14 1940

X

X

5-14-40

X

100-100000

2-16-40

100-100000

100-100000

CERTIFICATE OF DEATH

66034

Reg. Dist. No.

5900

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision)
o. STATE Dist. of Col. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Le Deau Gardens Nursing Home | | d. STREET ADDRESS
3814 Fulton St., N.W. | |
| 3. NAME OF DECEASED (Type or print)
First Orpha Middle V. Last Wilson | | 4. DATE OF DEATH
Month May Day 12 Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 25, 1882 |
| 9. AGE (In years last birthday) yrs. 77 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jonas Glatfelty | | 14. MOTHER'S MAIDEN NAME
Rebecca Specht | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Ruth D. Herbert, 3814 Fulton St., N.W. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Embolus
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease with Aneurysm
DUE TO
(c) Thrombosis
INTERVAL BETWEEN ONSET AND DEATH
48 hours
8 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Infarct; Diabetes Mellitus | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept 1, 1953 , to May 13, 1960 , that I last saw the deceased alive on May 12, 1960 , and that death occurred at 6:52 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Frank S. Bacon | | ADDRESS (Street, city or town, state) DATE SIGNED 1150 Conn. Ave. N.W. Washington, D.C. | |
| PHYSICIAN'S NAME (Type) Frank S. Bacon M.D. | | 1150 Conn. Ave. N.W. Washington, D.C. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
5/14/60 | 22c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | 22d. LOCATION (City, town, or county) (State)
Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Chung Chao Funeral Home | | 24a. REC'D BY REGISTRAR
DATE MAY 17 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4000

FOR STATE HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5922

07166

| | | | | | |
|---|-------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huattsville</u> 1664-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u> | | | d. STREET ADDRESS <u>7011 Colesville Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Edward Boyd Wise</u> | | | 4. DATE OF DEATH <u>May 26 1960</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 22, 1916</u> | 9. AGE (In years last birthday) <u>44</u> yrs. | IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Broker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Manitoba, Canada</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>John Frank Wise</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Elsie Boyd</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>2nd W.W. Army</u> | | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | | 17. INFORMANT <u>John Wise - Brother.</u> Address <u>—</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>SHOCK</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ABDOMINAL HEMORRHAGE</u>
DUE TO (c) <u>LACERATIONS, MULTIPLE, LIVER.</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>SUDDEN</u>
<u>↓</u>
<u>11</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS <u>—</u> PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Driver of auto which left highway - ran into ditch</u> | | | |
| TIME OF INJURY Month, Day, Year
Hour a.m. <u>4:45 a.m.</u> <u>5-26-1960</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u> | | 20f. (City or town) (County) (State)
<u>Adelphi P. G. Md</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | 22b. DATE THEREOF <u>MAY 28 1960</u> | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fork Lincoln</u> | | | 22d. LOCATION (City, town, or country) (State) <u>Bladensburg Md</u> | | |
| 23. FUNERAL DIRECTOR <u>Funeral Home</u> ADDRESS <u>4812 Ladue Rd</u> | | | 24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | |

1993

0310

03 1000

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5901 **CERTIFICATE OF DEATH** **06035**

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | c. LENGTH OF STAY IN 1b
10 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
229 GRANVILLE DRIVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Wolchick Last | | 4. DATE OF DEATH
Month May Day 23 Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 29, 1899 |
| 9. AGE (In years lost birthday) yrs.
60 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Beading | | 10b. KIND OF BUSINESS OR INDUSTRY
Tire Manufacturing | |
| 11. BIRTHPLACE (State or foreign country)
Sheridan, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Stephen Herrick | | 14. MOTHER'S MAIDEN NAME
Mary unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
yes | |
| 17. INFORMANT
Mr. Theodore Wolchick, 229 Granville Drive Silver Spring, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
153.8 METASTATIC CARCINOMA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. }
CARCINOMA OF COLON
DUE TO
5 MOS
INTERVAL BETWEEN ONSET AND DEATH
21 DAYS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 2/1 19 60 to 5/23 19 60 , that (I) (we) last saw the deceased alive on 5/23 19 60 , and that death occurred at 4:50 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John H. Tuohy | | 22b. DATE
5/23/60 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN H. TUOHY | | 22d. ADDRESS
7720 WISCONSIN AVE BETHESDA 14, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | 23b. DATE THEREOF
5/23/60 | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CREMATORY | 23d. LOCATION (City, town, or county) (State)
PRINCE GEORGE COUNTY, MD. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
WERNER E. PUMPHREY INC. Raymond A. Zicka | | 25a. REC'D BY REGISTRAR
DATE MAY 24 '60 | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus |

CERTIFICATE OF DEATH

1901

(M)

22

(I)

STATISTIC
CANCER OF

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06036

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE <i>md</i> b. COUNTY <i>P. Y.</i> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b
<i>7 hrs</i> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Adelphi</i> | | d. STREET ADDRESS
<i>2200 Phelps Rd</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>North Saint Mary's Hosp</i> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>John</i> Middle <i>George</i> Last <i>Wolf Jr.</i> | | | | 4. DATE OF DEATH
Month <i>May</i> Day <i>12</i> Year <i>1960</i> | | | |
| 5. SEX
<i>Male</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>12-24-37</i> | |
| 9. AGE (In years last birthday)
<i>22</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Apprentice</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Pa</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>John G. Wolf</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Marie Shields</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<i>Informant</i> | | 17. ADDRESS
<i>Hosp Record</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>
821X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Fracture of skull</i>
DUE TO
(c) <i>crushed chest</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Fracture of femur - Fracture of tibia</i> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<i>motorcycle acc. crashed in to residence -rte.501</i> | | | | | |
| 20c. TIME OF INJURY
Hour <i>7:50</i> a.m. <i>5-11</i> p.m. <i>1960</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<i>highway</i> | | 20f. (City or town) (County) (State)
<i>Adelphi P.Y. md</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschant</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) <i>5-12-60</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>May 14, 1960</i> | | 22c. NAME OF CEMETERY OR CREMATORY
<i>Ft Lincoln Cemetery</i> | | 22d. LOCATION (City, town, or country) (State)
<i>Colmar Manor, Md.</i> | |
| 23. FUNERAL DIRECTOR
<i>F. Gasch's Sons</i> | | | | 24a. REC'D BY REGISTRAR
<i>DATE MAY 16 '60</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Charles S. Hoad</i> | |

MEDICAL CERTIFICATION

11-11-11
THE 11th
11-11-11

1931

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5930 Item 9 File 6263 5-20-60 et
CERTIFICATE OF DEATH

66037

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
7104 Oak Ridge Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Frances Middle J Last Woodward | | 4. DATE OF DEATH
Month MAY Day 13 Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/3/97 |
| 9. AGE (In years last birthday)
72 62 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 10 Hours Min. | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
---- | |
| 11. BIRTHPLACE (State or foreign country)
Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
Rudolph Ullmar | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Daughter | | Address Maryland
Mrs. Powell-8004 Beech Tree Rd. Bethesda | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis of lungs
170X DUE TO pleura and bones
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma left breast
(c) 5 years. | | | INTERVAL BETWEEN ONSET AND DEATH
10 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 55 to present , that (I) (we) last saw the deceased alive on May 12, 1960 , and that death occurred 12:05 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
C. P. Ryland | | 22b. DATE SIGNED
5-13-60 | |
| 22c. PHYSICIAN'S NAME (Type)
C. P. RYLAND | | 22d. ADDRESS
4400-49th St. NW Washington 16 DC. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/17/60 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION (City, town, or county) (State)
Arlington, Virginia |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | 25a. REC'D BY REGISTRAR
DATE MAY 16 '60 | 25b. REGISTRAR'S SIGNATURE
Carlton S. Kraus |

X

1

1930

CERTIFICATE OF DEATH

MONTGOMERY

MARYLAND

Cherry Chase

15 yrs

Cherry Chase

7100 Oak Ridge Avenue

7100 Oak Ridge Ave.

Frances

Woodward

Female White

10/15/17

73 10 10

Housewife

Washington B. D. 12

Unknown Ulfert

Unknown

None

Daughter

Maryland

1001-1001 1001-1001 1001-1001

1001-1001

1001-1001

1001-1001

1001-1001

1001-1001

1001-1001

1001-1001

1001-1001

1001-1001

Robert A. Kennedy, Secretary, Md.

Arthur A. Kingston, Treasurer

William A. Kingston, Secretary

6072

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
4½ days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Josephine Middle R. Last Wyckoff | | 4. DATE OF DEATH
Month May Day 1 Year 19 60 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-5-23 |
| 9. AGE (In years last birthday)
37 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (State or foreign country)
Nebraska | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Dr Edward E. Sweeney | | 14. MOTHER'S MAIDEN NAME
Johanna Lyhene | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
None yes | |
| 17. INFORMANT
Charles W. Wyckoff | | Address 1102 Meurilee Lane Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
587.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Acute Pancreatitis
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
6 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 24 1960 to May 1 1960 that I last saw the deceased alive on May 1 1960 , and that death occurred at 5:30 PM from the causes and on the date stated above.
ADDRESS (street, city or town, state) DATE SIGNED
10620 Georgia Ave 5/1/60
Silver Spring, Md | | | |
| ACTUAL SIGNATURE
John J. Curry M.D. | | PHYSICIAN'S NAME (Type)
JOHN J. CURRY | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
5/4/60 | 22c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEMETERY | 22d. LOCATION (City, town, or county) (State)
ARLINGTON, VIRGINIA |
| 23. FUNERAL DIRECTOR'S SIGNATURE
WARNER E. PUMPHREY, INC
Diamond & Griska | | 24a. REC'D BY REGISTRAR
DATE MAY 3 '60 | 24b. REGISTRAR'S SIGNATURE
Charles E. Hays |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

